

**Therapists' Views on the Challenges and Helpful Factors in Long-Term Psychoanalytic Therapy for Treatment-Resistant Depression**

**Guy Maissis**

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**University College London**

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**Thesis declaration form**

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

Name: Guy Maissis

Date: 31 July 2018

## **Overview**

This thesis focuses on the research into long-term psychoanalytic therapy. The effectiveness of this form of therapy has been demonstrated in recent years, and thus, this thesis aimed to develop an understanding of the factors that are associated with its outcome.

Part 1 provides a systematic review of the studies investigating process-outcome research in long-term psychoanalytic-informed therapies. It highlights the urgent need to conduct more robust and better designed studies, as the overall quality of the studies found was low and therefore provided little conclusive evidence regarding how and why these therapies work. Clinical implications of the synthesised findings were discussed, highlighting the potential benefits of using psychoanalytic technique and inducing structural changes for long-term outcome.

Part 2 consists of a study exploring therapists' views on the challenges and helpful factors in long-term psychoanalytic therapy for treatment-resistant depression. Interviews conducted with therapists were analysed using thematic analysis, which found two main helpful factors: the formation of a containing and meaningful therapeutic relationship and the provision of an effective psychoanalytic intervention. The challenges and helpful factors in relation to these themes were identified and discussed.

Part 3 reflects on the experience of conducting research in the psychoanalytic field. It discusses the interface between researchers and therapists and the manner in which it can be improved.

## **Impact Statement**

### **Literature Review**

The review conducted in this thesis is the first systematic review of process-outcome research of long-term psychoanalytic and psychodynamic therapies. Its main contribution is that it highlights the urgent need to conduct more robust and better designed studies. This, as the review demonstrated that findings were significantly hampered by low internal validity and the lack of components required for investigating the mechanisms of change. In other words, it reflected that the research of these therapies currently reveals little about how and why these forms of therapy work, which stands in stark contrast to their demonstrated effectiveness. Recommendations for future research were formed to provide suggestions on how to advance the knowledgebase, which would allow for the optimisation of these therapies.

Despite the limitations outlined, the findings of the review showed that use of psychoanalytic technique significantly mediated the outcome of long-term psychoanalytic therapy. This has clinical implications as it suggests that more prominent use of this technique can result in better long-term outcome. Other findings have been less robust, however, they have provided support for psychoanalytic theories of change. In terms of clinical implications, they suggest that therapies would benefit from focusing on inducing structural changes to achieve long-term reduction of symptoms.

### **Empirical Paper**

The empirical paper in this thesis is the first qualitative analysis of therapists' views of the factors involved in the treatment of patients with treatment-resistant depression (TRD). It identified a large amount of factors that are potentially associated

with long-term outcome of these therapies, thus, providing many research questions for future research, which, as highlighted in the literature review, is currently lacking. These findings will be disseminated via publication in a peer-reviewed journal and via presentations at two conferences<sup>1</sup>. They will also be used in a future study comparing therapists' and patients' views of these therapies.

This study also has impact with regards to research methods, as it demonstrated the potential in integrating qualitative study into randomized controlled trials. It also demonstrated the benefits of conducting therapies as part of study, as the research setting was identified as having a positive effect on outcome. This can help mitigate therapists' concerns regarding participating in studies, which is often reported by researchers in the field.

This study also has clinical implications. It suggests the therapists should focus on the formation of patients' experience of the therapeutic relationship as containing and meaningful, before directly addressing their pathologies, as this may exacerbate their difficulties. It also suggests that this is achieved by effective containment of patients over an extended period of time. It highlights the challenges in this regard as well as the factors that are helpful to overcoming them, which are supervision and the use of external factors. The latter is especially important as psychoanalytic literature does not often examine the contribution of factors outside the therapy room. The study also suggests the therapists should not focus exclusively on patients' insight gain, as its relationship with long-term outcome was questioned, but also focus on changes in patients' internal structures and developing their self-analytical capacities.

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<sup>1</sup> These conferences are the British Psychological Society in May and the international conference of the Society for Psychotherapy Research in June

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**Part 1: Literature Review**

**Systematic Review of Process Factors Associated with Long-Term Outcome of  
Psychoanalytic and Psychodynamic therapies**

## **Abstract**

**Aims:** This review aimed to provide an up-to-date and systematic examination and appraisal of studies investigating the therapeutic process factors associated with outcome of long-term psychoanalytic and psychodynamic therapies.

**Method:** Studies were selected following a systematic search of PsycInfo, Ovid Medline and Open Door Review and were included based on clearly defined selection criteria. Studies' quality was assessed based on measures taken to reduce risk to internal validity and the scope of their exploration of the process-outcome relationship.

**Results:** Of the 3,647 entries identified, 16 studies were included for review. Synthesising their findings revealed that 18 process factors were investigated, 12 of which were found to have a significant association with outcome. These were grouped into the following categories: therapists' self-identified characteristics; changes in patients' structural configurations; and, the therapeutic technique. The overall quality of the studies was low.

**Conclusions:** Given the range of the findings and the low quality of the studies, it was not possible to make conclusive statements about the process factors that are associated with outcome in psychoanalytic and psychodynamic psychotherapies. Specifically, the studies' designs, which generally omitted the components required for the investigation of the process factors as mediators, hindered the capacity to develop an understanding of the mechanisms of change. Nonetheless, the findings broadly demonstrated a relationship between changes in internal structural and long-term reduction of symptoms, which supported psychoanalytic theory of change. The findings suggest that future studies should include larger sample sizes, theory informed research questions, and adopt a more sophisticated research design. This, to explore the link between process and outcome factors beyond their predictive relationship.

## **1. Introduction**

Recent years have seen emerging evidence for the effectiveness of long-term psychoanalytic and psychodynamic therapies for a variety of mental health difficulties (Leichsenring, Abbass, Luyten, Hilsenroth & Rabung, 2013). Whilst there are varying views as to what constitutes a long-term treatment in different countries, one generally accepted definition refers to a minimum of 50 sessions or at least one year of treatment (Leichsenring & Rabung, 2011; Leichsenring et al., 2013). These therapies share similar theoretical foundations to shorter psychoanalytic and psychodynamic therapies, however, they are different in their scope, planning and execution as they aim to encompass and address a wide variety of aspects of patients' personality and pathology. Accordingly, they are considered especially suitable for more complex mental health difficulties (Gabbard, 2017). This has been supported by evidence from recent studies and meta-analyses which demonstrated that long-term psychoanalytic and psychodynamic therapies have been found superior in comparison to their short-term or moderate-length counterparts for the treatment of complex and chronic mental disorders (Fonagy, 2015; Knekt, Virtala, Härkänen, Vaarama, Lehtonen & Lindfors, 2016; Leichsenring et al., 2015; Woll & Schönbrodt, 2018). However, despite these positive results, not all of the patients treated by long-term psychoanalytic and psychodynamic therapies improve. As such, identifying the factors associated with outcome is important, as it allows to tailor and optimise the treatment.

The study of the factors associated with therapy outcome can be traced back to the early days of psychotherapy, to Freud's (1913) conceptualisation of psychoanalysis as a new science in need of developing its knowledgebase. Although Freud did not suggest that this be achieved via an empirical systematic approach, psychotherapy research became much more systematic around the middle of the 20<sup>th</sup>

century (Braakmann, 2015). Around that time, researchers began to address the inherent bias and difficulties in generalising therapists' retrospective accounts of therapies, which had been the main source of knowledge until that point (Wallerstein, 2001).

Thus, a new area of research was established, that came to be known as process-outcome research, as it integrated the investigation of two areas of research: process research and outcome research (Gelo & Manzo, 2015). Process research is highly inclusive by its definition as it aims to investigate the factors that are potential constituents of the therapy, i.e., the factors that are relevant to what transpires during and between the therapy sessions in terms of the "participants' experiences, perceptions and their behavioural interactions" (Orlinksy, 2009, p. 319). In comparison, the definition of outcome research has been much more the subject of debate, resulting, in recent years, in a clearer demarcation: it currently refers, most frequently, to the changes in patients' distress, symptoms and functioning (Christoph, Gibbons and Mukherjee, 2013). As opposed to process research, outcome research tends to utilise quantitative standardised measures, which are deemed as necessary to address and mitigate therapists' biases in their assessments of outcome (Ogles, 2013).

Another important current aspect of outcome research is the inclusion of a follow-up period after termination of the therapy (Chambless & Hollon, 1998). As many researchers have reflected, this is especially important when the aim of the therapies is to establish long-lasting changes (Kendall, Holmbeck & Verduin, 2004; Llewellyn-Bennett, Bowman & Bulbulia 2016). The inclusion of a long-term follow-up has been found to be especially important for the study of psychoanalytic and psychodynamic therapies, as according to their theory of change, patients enter a post-analytic phase after the end of treatment, during which structural changes are still

taking place (Thomä & Kächele, 1987). It is further argued that only after these structural changes have been established, can changes in the patients' functioning, symptoms and distress be observed (Grande et al., 2009; Wallerstein, 2001).

One of the first seminal reviews of process-outcome research in psychotherapy was Luborsky, Auerbach, Chandler, Cohen and Bachrach's (1971) review. The aims of that review were threefold: (a) to identify the factors that are associated with outcome (b); to highlight the clinical factors that are theorised but have yet to be systemically researched; and, (c) to evaluate the methodology of the existing research in order to form recommendations for future research. These particular aims have continued to guide process-outcome research, which has rapidly grown in prevalence in recent decades (Orlinsky, Rønnestad, & Willutzki, 2004). Accordingly, recent years have seen an increase in the reviews of the factors associated with outcome. These reviews have become more specific with regards to diagnoses, such as depression (Lemmens, Müller, Arntz & Huibers, 2016), borderline personality disorder (Barnicot, Katsakou, Bhatti, Savill, Fearn & Priebe, 2012), obsessive compulsive disorder (Knopp, Knowles, Bee, Lovell & Bower, 2013), and disordered gambling (Merkouris, Thomas, Browning & Dowling, 2016), as well as with regards to specific therapy models (Rudge, Feigenbaum & Fonagy, 2017; Velden et al., 2015).

The method used to investigate factors associated with outcome has grown more sophisticated over the years, with researchers advocating the need to study such factors beyond their predictive association with outcome. This, in order to understand how, why and for whom therapy works, by investigating whether these factors are moderators or mediators of outcome: the former, identify for whom and in what circumstances therapy is effective; while the latter, identify the mechanisms of the therapeutic change, also known as therapy's "active ingredients" (Baron & Kenny,

1986). This distinction has become more integrated into process-outcome research in recent years as studies adopted the rigorous research framework suggested by Kazdin (2007), which requires repeated measurements of process and outcome factors in addition to a statistical mediation analysis. Identifying and distinguishing between moderators and mediators is considered to be highly valuable for therapy as such distinction can inform decision making as to the type of intervention to be provided, and as it can also refine and enhance the therapeutic intervention and its outcome (Kraemer, Wilson, Fairburn & Agras, 2002).

The investigation of the process factors associated with outcome in psychoanalytic and psychodynamic therapies has been limited in comparison to other therapy models, in terms of both the number of studies published, and their methodological sophistication (Barber, Muran, McCarthy & Keefe, 2013). However, investigation of these factors has been considered to be increasing gradually on both accounts in recent years, as reported in Barber et al.'s (2013) summary of psychoanalytic and psychodynamic research, in Minges, Solomonov and Barber's (2017) summary of studies investigating mediators within these therapies, and as demonstrated in Lingardi, Muzi, Tanzilli and Carone's (2018) review of therapists' variables associated with outcome in psychodynamic therapies.

Thus far, most studies have focused on short-to-moderate term therapies (Luyten, Blatt & Mayes, 2012). As such, there is a need to identify the process factors, and specifically the moderators and mediators, associated with the outcome of long-term psychoanalytical and psychodynamic therapies. Such investigation would allow to develop a better understanding of the suitability of these therapies to different circumstances and of their active ingredients, which could enhance their effectiveness (Fonagy, 2002).

It should be noted that the reviews of research on psychoanalytic and psychodynamic therapies mentioned above did not make a distinction in their findings between the different models of those therapies, i.e., between psychoanalysis, psychoanalytic therapy and psychodynamic therapy. This lack of distinction has been attributed to a dearth of clear consensus regarding the differences between these therapies. As such, most studies comparing these therapies rely on extrinsic criteria to differentiate between them, which is often based on therapists' qualifications and licensing, frequency of sessions and length of treatment. However, it should be stated that there is no uniformity in the definition of these extrinsic criteria between studies, as it is often based on national guidelines. For example, psychoanalytic and psychodynamic therapies consisted of two to three sessions per week in studies held in Finland and Sweden (Knekt et al., 2011; Sandell et al., 2000), however, in a German study, which followed the German guidelines, psychodynamic therapy was defined as only one session per week (Huber et al., 2013).

In addition, differentiation based on intrinsic criteria, i.e., theory and practice, have not been utilised in research, as it is a subject of great debate, which currently lacks any resolution (Barber et al., 2013; Blass, 2010). As such, some have suggested that any distinction between the models to be ultimately inconsequential as all the models are informed by psychoanalytic theory (Fosshage, 1997; Wallerstien, 2001), which is highly pluralistic and fragmented within itself (Fonagy, 2000; Grünbaum, 2001). In addition, the significant differences in extrinsic and intrinsic criteria based on country have also been highlighted as a significant factor that greatly obscures the possibility of distinction (Grant & Sandell, 2004). In contrast, others (Blatt & Shahar, 2004; Kernberg, 1999; Kächele, 2010) have conceptualised a variety of frameworks



demarcating key differences between the therapy models, with some suggesting that these differences result in different outcomes based on patients' characteristics.

Ultimately, this discussion has been mostly theoretical, inconclusive and empirically considered as “barely explored systematically” (Gazillo et al., 2018, p. 184). This, as only three studies were found to directly compare outcomes based on different models, with contradicting results and methodological limitations (Huber, Henrich, Clarkin & Klug, 2013; Knekt et al., 2011; Sandell et al., 2000). As such, it was decided in this review to also aggregate the different models in its systematic search and review of findings.

No systematic review of the studies exploring the factors associated with outcome in long-term psychoanalytic and psychodynamic therapies exists. It should be stated that in general, process-outcome research of long-term psychoanalytic and psychodynamic therapies has been considered as limited or “almost non-existent” (Blomberg, Lazar and Sandell, 2001, p. 362). However, this seemingly has begun to change in the past decade with a noticeable increase in the number of studies published (Busch & Milrod, 2010).

Thus, it appears timely to systematically review the process-outcome research of long-term psychoanalytic and psychodynamic therapies. The aim of this review is threefold: (a) to review the various process factors associated with treatment outcome; (b) to evaluate the quality of the evidence; and, (c) to form recommendations for future studies.

## **2. Method**

### **2.1 Inclusion Criteria**

Based on theory and the review aims outlined above, the following study inclusion criteria were determined:

1. Studies that examined therapies that used a treatment model based on psychoanalytic principles and as such were termed and self-identified as ‘psychoanalysis’, ‘psychoanalytic’ or ‘psychodynamic’ therapies and were conducted in an outpatient individual setting with adults (age 18 and above).
2. Studies that examined therapies that consisted of at least 50 sessions and at least one year of treatment.
3. Studies that explored the relationship between process factors and outcome. Outcome needed to be defined as a change in patients’ distress, symptoms and/or functioning, and its measures assessed as reliable and valid.
4. Studies that used a correlational or experimental design (case studies were excluded).
5. Studies that included a post-treatment follow-up period in their process-outcome analysis.
6. Studies that were published in a peer-reviewed journal.

## **2.2 Search Strategy**

Studies were identified through searching the PsycInfo and Ovid Medline electronic databases. Both were selected because of their extensive coverage of both mental health publications and their psychotherapeutic treatment. In addition, the second and third editions of the Open Door Review (2002, 2015), which aggregates contemporary process and outcome research of psychoanalysis and psychodynamic psychotherapies, were manually reviewed. Figure 1 provides the systematic search strategy utilised and its results.

Entries' fields of title, keywords and abstract were searched for the following terms: 1) psychoanalysis, psychoanalytic or psychodynamic therapies; 2) outcome research (including any change in symptoms and functioning); and, 3) process research. Terms were intentionally inclusive and did not specify particular process areas (such as therapist effects, working alliance, insight and others).

Results were screened by title and abstract manually to identify process-outcome studies which met the inclusion criteria, thus removing entries which were: 1) non-studies (such as literature reviews or theoretical papers); 2) focused exclusively on outcome or process but not on the relationship between the two (such as efficacy and effectiveness studies); or, 3) studies of other interventions and settings not defined by the inclusion criteria (such as non-psychodynamic therapies and/or group therapy).

In a final step, studies were identified by scanning their full-text to determine: whether they met the remaining inclusion criteria of length of treatment; whether a post-treatment follow-up period was included; the type of outcome measured; and, whether an analysis of the process variables in relationship to the outcome was conducted.

### **2.3 Quality Appraisal**

Each eligible study was systematically appraised. The quality of the studies in this review was appraised by: (a) the measures taken to reduce bias and risk to internal validity; and, (b) the measures taken to provide a thorough exploration of the relationship between the process factors and the outcome, i.e., whether these studies attempted to examine the hypotheses of these process factors as predictors, moderators or mediators, by incorporating this investigation into their design, as suggested by Kazdin (2007).

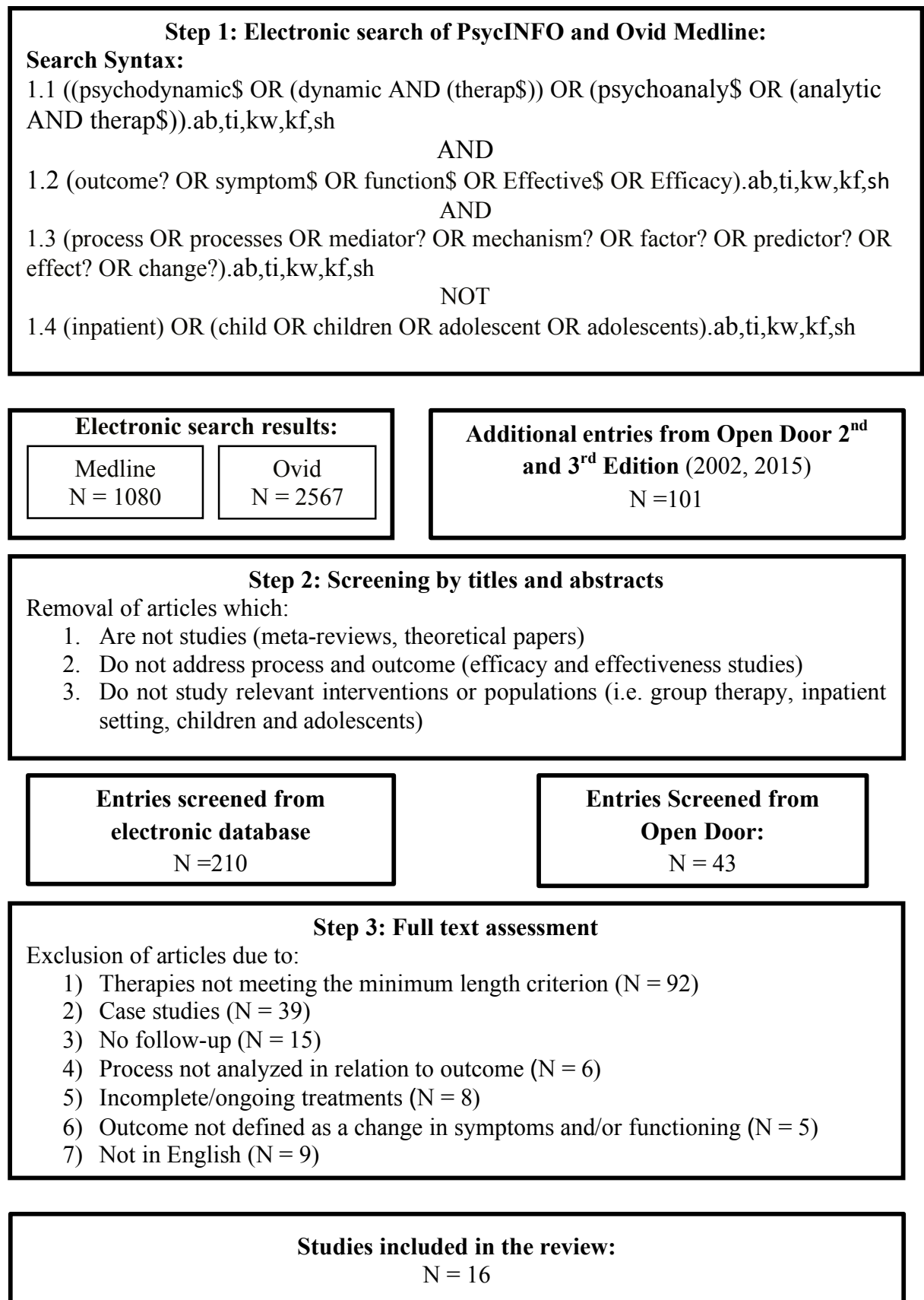
The appraisal consisted of a checklist which combined the criteria used in Barnicot et al.'s (2012) review of process factors as predictors of outcome; and the criteria used in Lingiardi, Muzi, Tanzilli and Carone's (2018) review of mechanisms of change. The following criteria were assessed: (1) whether the study followed a Randomised Controlled Trial (RCT) design; (2) whether the study included randomisation by an independent person or computer; (3) if participants were not randomised, whether participants' characteristics were examined to assess differences between the groups; (4) whether the study included a control/comparison group; (5) whether missing data was reported and assessed; (6) whether the study included a sufficient sample size (defined as  $N \geq 40$ ); (7) whether treatment integrity was checked; (8) whether the analysis followed the intention-to-treat principle; (9) whether outcomes measures were valid and reliable; (10) whether outcome assessors were blind; (11) whether process measures were assessed for validity and reliability; (12) whether repeated measures of the outcome and process were included (three or more measurement points); (13) whether the study design included an experimental manipulation of the process factors; (14) whether process measures were analysed as continuous rather than dichotomized or categorical, if appropriate; and, (15) whether mediation analysis was included.

Following Barnicot et al. (2012), each of the studies in the review was scored either one, zero or not-relevant for each criterion. The sum of scores was then divided by the number of criteria relevant for each study, which produced a score between zero and one reflecting its quality. The studies' overall level of quality was determined based on their score and its placement within the following categories: low ( $\leq 0.5$ ), moderate ( $> 0.5$  and  $< 0.7$ ) and high ( $\geq 0.7$  and  $\leq 1.0$ ), as suggested by Barnicot et al. (2012).

### **3. Results**

#### **3.1 Search Results**

The systematic search of the electronic databased identified 3,647 studies. The manual review of the articles reported in the Open Door Reviews yielded 43 studies, of which only one was not found in the electronic search. After screening the title and abstract, 210 studies remained; after reading the full texts, 16 studies were included in this review. The complete search process is illustrated in Figure 1.



*Figure 1.* Diagram illustrating the search process

### **3.2 Excluded Studies**

The main reason for exclusion was the studies' treatment lengths; 92 studies conducted brief or moderate-length psychoanalytic and psychodynamic therapies below the minimum of 50 sessions. An example was the FEST study (Hoglend et al., 2006), which explored the role of transference interpretation. The second most common cause for exclusion was case study design (N = 39). An example was Brockmann et al.'s (2017) case study which included standardised outcome monitoring of up to two years after the completion of treatment. The third most common cause for exclusion was a lack of follow-up period (N = 15). An example was Werbart, Hägertz and Ölander's (2018) study of patients and therapists' anaclitic and introjective personality configurations, which did not include in its analysis the follow-up outcome collected in its main study. An overview of the excluded studies can be found in Figure 1.

### **3.3 Included Studies Characteristics**

The 16 included studies were all based on data collected as part of larger research projects (N=7) and included the following: The Munich Psychotherapy Study (MPS; Huber, Henrich, Clarkin & Klug, 2013), the Young Adult Psychotherapy Project (YAPP; Philips et al., 2006), the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP; Sandell et al., 2000), the Norwegian Multisite Study of Process and Outcome in Psychotherapy (NMSPOP; Havik et al., 1995), the Long-Term Dynamic Psychotherapy Research Project (LTDPR; Bond & Perry, 2004), the Helsinki Psychotherapy Study (HPS; Knekt et al., 2008) and an unspecified project conducted at Stockholm's Institute of Psychotherapy (Werbart & Forsstrom, 2014). A summary of these projects is reviewed in Appendix A.

All of the research projects examined therapies that were provided by experienced therapists (pooled average was 11.06 years of experience). The most examined treatment model was once-weekly psychodynamic therapy. The exceptions were: the MPS study, which in addition to the psychodynamic therapy also investigated psychoanalytic therapy consisting of two-three sessions per week; the STOPPP, which in addition to psychodynamic therapy also included five-times per week psychoanalysis; Werbart and Forsstrom's (2014) study, which investigated only four-times per week psychoanalysis; and, YAPP, which investigated only psychoanalytic therapy consisting of one-two sessions per week.

All studies included patients from the general adult population, except the YAPP, which focused on 18-25 year olds. All of the studies, except the MPS, which focused specifically on the treatment of depression, treated patients with a variety of mental health difficulties, including anxiety, mood difficulties and personality disorders.

Follow-up assessment periods after the end of treatment varied between the studies, ranging between one-and-a-half and three years. In terms of outcome measures used, most studies included the Symptom Checklist-90 (SCL-90) and the Global Severity Index (GSI) derived from it, the Inventory of Interpersonal Problems (IIP), the Beck Depression Inventory (BDI), and the Global Assessment of Functioning (GAF). Process variables and measures varied greatly between studies and will be outlined in greater detail below. The complete characteristics of the included studies are summarised in Table 1.



Table 1

*Characteristics of the Studies Included in the Review*

Study	Treatment	Main difficulties	Sample(s)	Therapists (average years of experience)	Treatment duration (in months)	Number of sessions	Post therapy follow-up (in years)	Outcome measures	Outcome measurement	Process measures	Process measurement	Main study
Zimmermann et al. (2015)	PA, PDT, CBT	Depressive disorder	PA (N = 35), PDT (N = 31), CBT (N = 34)	N = 14 (M = 15)	PA (M = 39.3, SD = 16.6), PDT (M = 32.6, SD = 24.2)	PA(M = 241.3, SD = 89.9), PDT (M = 85.4, SD = 56.5)	3	BDI, IIP-C	Every 6 months in treatment and annually in follow-up	PQS, number of sessions	3 sessions mid-treatment	MPS
Klug et al. (2016)	PA, PDT, CBT	Depressive disorder	PA (N = 35), PDT (N = 31), CBT (N = 34)	N = 14 (M = 15)	PA (M = 39.3, SD = 16.6), PDT (M = 32.6, SD = 24.2)	PA(M = 241.3, SD = 89.9), PDT(M = 85.4, SD = 56.5)	3	BDI, GSI, IIP	Every 6 months during treatment, and every year in follow-up	HAQ-T, HAQ-P, INTREX	Every 6 months	MPS
Huber et al. (2017)	PA, PDT, CBT	Depressive disorder	PA (N = 35), PDT (N = 31), CBT (N = 34)	N = 14 (M = 15)	PA (M = 39.3, SD = 16.6), PD (M = 32.6, SD = 24.2)	PA (M = 241.3, SD = 89.9), PD (M = 85.4, SD = 56.5)	3	BDI, GSI	Pre-treatment, termination and at 3 years follow-up	SPC	Pre-treatment and termination	MPS
Sandell et al. (2000)	PA, PDT	Not specified	PA (N = 74), PDT (N = 331)	N = 209 (M = ?)	PA (M = 54; SD = 23), PDT (M = 46; SD = 24)	PA ((M = 642, SD = 324), PDT (M = 233, SD = 151)	3	SCL-90	Annually	TIQ	Pre-treatment	STOPPP
Sandell et al. (2007)	PA, PDT	Not specified	PA (N = 35), PDT (N = 187)	N = 108 (M = ?)	PA (M = 54, SD = 23), PDT(M = 46, SD = 24)	PA (M = 642, SD = 324), PDT (M = 233, SD = 151)	2	SCL-90	Annually	TIQ	Pre-treatment	STOPPP
Sandell et al. (2006)	PA, PDT	Not specified	PA (N = 53), PD (N = 264), Non-clinical (N = 188)	N = 167 (M = ?)	PA (M = 54, SD = 23), PDT(M = 46, SD = 24)	PA (M = 642, SD = 324), PDT (M = 233, SD = 151)	2	SCL-90	Annually	TIQ	Pre-treatment	STOPPP
Falkenström et al. (2007)	PA, PDT	Not specified	PA (N = 10), PDT (N = 10)	?	?	?	2	SCL-90	Annually	Change interview	1 and 2 years post termination	STOPPP
Lindgren et al. (2010)	PA – Individual and group	Depression, anxiety, OCD, PD	Individual PA (N = 92), Group PA (N = 42)	N = 37 (M = 10.3)	M = 19, SD = 13.8	?	1.5	SCL-90	Pre-treatment, termination and at 1.5 years follow-up	HAQ-II-T, HAQ-II-P	Every 3 months	YAPP

Lilliengren et al. (2015)	PA – Individual and group	Depression, anxiety, OCD, PD	Individual (N = 92), Group (N = 42)	N = 32 (M = 10)	M = 23, SD = 13.0	?	1.5	SCL-90, GAF, IIP	Pre-treatment, termination and at 1.5 years follow-up	PAT, HAQ-II-P	Near termination	YAPP
Werbart at al. (2017)	PA – Individual and group	Depression, anxiety, OCD, PD	N = 33	N = 22 (M = 10.7, SD = 4.1)	M = 23.7, SD = 12.6	?	3	SCL-90	Pre-treatment, termination and at 1.5 and 3 years follow-up	ORI	Pre-treatment, termination and at 1.5 and 3 years follow-up	YAPP
Heinonen et al. (2014)	PA, PDT	Anxiety and mood disorders	PA (N = 41), PDT (N = 129)	N = 58 (M = ?)	PA (M = 56.3, SD = 21.3), PDT (M = 31.3, SD = 11.9)	?	Varies (5 years overall)	GSI	Annually for 5 years	DPCCQ	Pre-treatment	HPS
Knecht at al. (2017)	PDT	Anxiety and mood disorders	PDT (N = 128)	PDT (N = 41)	PDT (M = 31.3, SD = 11.9)	?	Varies (5 years overall)	GAF, SCL-90	Annually for 5 years	LPO	Pre-treatment	HPS
Bond and Perry (2004)	PA, PDT	Anxiety and mood disorders	N = 53	N = 22 (M = 13.1)	M = 36, SD = 25.2	?	Varies (M = 4.2, SD = 2.0)	GAF, SCL-90	Every 6 months	DSQ	Every 6 months	LTDPR
Werbart & Forsstrom (2014)	PA	Anxiety and mood disorders	N = 14	N = 8 (M = 8)	M = 61, SD = 14.7	?	2	SCL-90-GSI,	Pre-treatment, termination and at 2 years follow-up	Change interview	Termination and at 2 year follow-up	?
Nissen-Lie et al. (2013)	PDT	Anxiety, mood and personality disorders	N = 255	N = 46 (M = 10, SD = 6.57)	?	M = 51, SD = 59	2	GAF, SCL-90, IIP-64	Pre-treatment, termination and at 0.5, 1 and 2 years follow-up	DPCCQ	Completed a maximum amount of 6 times during 1 year	NMSPOP
Solbakken et al. (2017)	PDT	Anxiety, mood and personality disorders	N = 153	N = 35 (M = ?)	?	M = 72, SD = ?	2	GAF, SCL-90, IIP-64	Pre-treatment, termination and at 0.5, 1 and 2 years follow-up	AC interview, WAI	AC at pre-treatment; WAI at session 3	NMSPOP

*Note.* PDT = Psychodynamic Therapy; PA = Psychoanalytic Therapy; CBT = Cognitive Behavioural Therapy; BDI = Beck Depression Inventory; IIP = Interpersonal Problems; INTREX = Introject Affiliation; HAQ = Helping Alliance Questionnaire; SPC = Scales of Psychological Capacities; SCL-90 = Symptom CheckList-90; GAF = Global Assessment of Functioning; ORI = Object Relations Interview; DPCCQ = The Development of Psychotherapists Common Core Questionnaire; DSQ = Defense Style Questionnaire; NLP – Negative Life events; TIQ - Therapeutic Identity Questionnaire; LPO = Level of Personality Organization; AC = Affect Consciousness.

### **3.4 Quality Appraisal**

In summary, all of the studies used outcome measures which were well-known, standardised and with reports of high reliability and validity (Aas, 2010; Derogatis & Unger, 2010; Huber, Henrich & Klug, 2007; Beck, Steer & Carbin, 1998). Whilst the process measures were not all established measures, all of the studies did assess their reliability and discussed issues with validity. Almost all of the studies reported missing data and assessed it appropriately.

The assessment also highlighted several areas which impacted the quality of the studies. None of the studies followed an RCT design, which is considered to be the gold standard of outcome research (Barton, 2000; Meldrum, 2000; NICE, 2012). Only about half of the studies had a comparison group and only about half of those assessed group differences. The methodological difficulties associated with the lack of these components were highlighted most clearly in Sandell et al.'s (2000) study, which reported significant differences between patients who decided to engage in psychoanalysis and patients who decided to engage in psychodynamic therapy. This resulted in a significant risk to internal validity, as the differences between the groups could explain the differences in outcome rather than the effect of the therapy model on outcome. This was eventually addressed and managed effectively in two follow-up studies by Sandell et al. (2006, 2007).

Several issues were identified with regards to the studies' investigation of the nature of the relationship between the process factors and outcome. None of the studies employed an experimental design which directly manipulated the process factors. Such design, for example, was used in the FEST study (Hoglund et al., 2006), which dismantled and examined the role of transference interpretations on outcome. Instead, all of these studies were either quasi-experimental or observational. Only three studies,

all of which used the MPS data, included mediation analysis as well as repeated measurements in their design. As such, the MPS studies were the only ones to receive a high quality rating, while the rest of the studies included in this review were rated as low, except Lindgren et al.'s (2010) study which was rated as moderate.

Another important limitation, which was relevant in seven of the studies, was their small sample size. This, as it affected these studies' ability to identify associations, due to their low power. The complete quality appraisal for each of the studies included is summarised in Table 2.

Table 2

*Quality Assessment of Included Studies*

Criterion	Study															
	Zimmermann et al. (2015)	Klug et al. (2016)	Huber et al. (2017)	Sandell et al. (2000)	Sandell et al. (2007)	Sandell et al. (2006)	Falkenström et al. (2007)	Lindgren et al. (2010)	Lilliengren et al. (2015)	Werbart et al. (2017)	Heinonen et al. (2014)	Knekt et al. (2014)	Bond and Perry (2004)	Werbart and Forsstrom (2014)	Nissen-Lie et al. (2013)	Solbakken et al. (2017)
(1) whether the study followed an RCT design;	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
(2) whether the study included randomization by independent person or computer;	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
(3) if participants were not randomised, whether participants' characteristics were examined to assess differences between the groups;	Y	Y	Y	N	Y	Y	Y	NR	NR	NR	N	N	NR	Y	NR	NR
(4) whether the study included a control/comparison group;	Y	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	N	Y	N	N
(5) whether missing data was reported and assessed;	Y	Y	Y	N	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(6) whether the study included sufficient sample size (defined as N ≥ 40);	N	N	N	Y	Y	Y	N	Y	Y	N	Y	Y	Y	N	Y	N
(8) whether treatment integrity was checked;	Y	Y	Y	N	N	N	N	Y	Y	Y	N	N	N	N	N	N

(9) whether the analysis followed intention-to-treat principle;	Y	Y	Y	N	N	N	N	N	N	N	Y	Y	N	N	N	N
(10) whether outcomes measures were valid and reliable;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(12) whether outcome assessors were blind;	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N	N	N
(13) whether process measures were valid and reliable;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(15) whether repeated measures of the outcome and process were included (3 or more measurement points);	Y	Y	y	N	N	N	N	Y	N	Y	N	N	Y	N	Y	Y
(16) whether the study design included an experimental manipulation of the process variables;	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
(17) whether process measures were analysed as continuous rather than dichotomized or categorical, if appropriate;	Y	Y	Y	N	N	N	NR	Y	Y	Y	N	N	Y	NR	Y	Y
(18) whether mediation analysis was included.	Y	Y	Y	N	N	y	N	N	N	N	N	N	N	N	N	N
Overall rating	High	High	High	Low	Low	Low	Low	Moderate	Low	Low	Low	Low	Low	Low	Low	Low

### **3.5 Review of Findings**

The main aim of the review was to identify process factors associated with outcome and the nature of their relationship. Overall, a wide variety of process factors were identified. It was decided that they be grouped into the following categories: (a) the therapist; (b) changes in patients' structural configurations; (c) the therapeutic relationship; (d) the therapeutic intervention; and, (e) patients' pre-treatment characteristics.

For a complete summary of the findings see Appendix B.

#### **3.5.1 The therapist.**

Five studies examined process factors related to the therapist. All of these studies used measures of self-report completed by the therapists pre-treatment. Two of the studies used the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky & Ronnestad, 2005) and the other three used the Therapeutic Identity questionnaire (ThId; Sandell, Blomberg & Lazar, 1997). Using these measures, the studies explored the relationship between outcome and therapists' self-reported professional and personal characteristics, such as their views on the curative factors in therapy and on their therapeutic and interpersonal style. Outcome was measured as change in symptoms and one of the studies also included interpersonal distress and overall functioning.

##### ***3.5.1.1 Therapists' characteristics and attitudes associated with change in symptom distress.***

Sandell et al. (2000, 2006) found three factors that were positively associated with reduction of symptoms: (a) therapists' views on their therapeutic style as being supportive; (b) therapists' views on kindness being a curative factor; and, (c)

therapists' views on therapy being a form of artistry. These aspects, with the exception of supportiveness, were also found to differentiate between groups of therapists based on the outcome of their therapies, in a latent class analysis that was based on the same data (Sandell et al., 2007). This analysis also reported that the most effective group of therapists had high ratings on viewing kindness as a curative factor, and that the group of the least effective therapists were rated low on viewing therapy as a form of artistry.

#### ***3.5.1.2 Differences between psychoanalysts and psychodynamic therapists.***

Sandell et al. (2000) found an interaction between the treatment model and therapists' views. They found that supportiveness, kindness and artistry were only found to be associated with outcome among psychodynamic therapists and not among psychoanalysts. Heinonen et al. (2013) reported a similar pattern, as therapists with low self-reported affirmative relational style in therapy were found to predict negative outcome for psychodynamic therapists but not for psychoanalysts. The quality appraisal found that both of these studies had the same methodological limitation, as they reported significant differences between psychoanalysts and psychodynamic therapists in a number of areas (such as age, years of experience and others). Thus any of these areas could potentially be a confounding factor. This was acknowledged by the studies but not addressed.

#### ***3.5.1.3 Therapists' variables associated with change in interpersonal distress.***

Nissen-Lie et al. (2013) examined the relationship between therapists' views and outcome as measured by interpersonal distress and global functioning. The study found that professional self-doubt had a positive relationship with interpersonal difficulties but not with symptom distress. Similarly, two other studies (Sandel 2006, 2007), which also explored the relationship between self-doubt and change in



symptom distress, did not report this relationship to be significant.

Nissen-Lie et al. (2013) also reported that therapists' self-identified negative personal response to their patients and their perception of themselves as having Advanced Relational Skills (ARS) were negatively associated with change in interpersonal distress but not in symptoms. ARS was found to be moderated by therapists' reports of having a warm interpersonal style. In addition, ARS was found to be related to changes in symptom distress, however only after patients' pre-treatment interpersonal distress was included in the analysis. This addition revealed an interaction effect, as patients with high pre-treatment interpersonal difficulties had a worse outcome when treated by therapists with high self-reported ARS, rather than when treated by therapists with low self-reported ARS. Patients with low pre-treatment interpersonal difficulties responded in a similar manner regardless of their therapists' self-reported ARS ratings.

### **3.5.2 Changes in patients' structural configurations.**

Six studies examined the relationship between outcome and the changes in patients' structural configurations. They were grouped into four categories.

#### ***3.5.2.1 Overall personality configuration.***

Huber et al. (2017) explored patients' overall personality configuration, using the Scales of Psychological Capacities (SPC; Huber, Brandl & Klug, 2004), which assessed different aspects of patients' mental structures and mechanisms (such as representations of self and others, neuroses, and use of defences). They found that the changes in patients' overall configuration were positively associated with reduction in symptoms. The study also explored the relationship between these structural changes, negative events in the patients' lives, and long-term outcome, in order to examine the

diathesis-stress theoretical model. The study reported an interaction, as patients who experienced negative life events after therapy reported higher levels of distress at the end of the follow-up, only when their overall improvement in personality configuration was low.

#### ***3.5.2.2 Anaclitic and Introjective (A/I) balance.***

Two studies (Werbart & Forsström, 2014; Werbart, Alan & Diedrichs, 2017) explored patients' anaclitic and introjective (A/I) configurations, which encompass patients' relatedness to others and self-definition. Both studies explored the changes in A/I balance in relation to outcome and reported contradictory results: Werbart and Forsström's (2014) study reported that reduction in symptoms was associated with better balance only for anaclitic patients and not for introjective patients. Werbart, Alan and Diedrichs (2017) reported that unexpectedly, more improved balance was found to be associated with lower levels of symptoms reduction. The quality appraisal found that both of these studies were limited by their very small sample size. In addition, both studies did not use measures which directly differentiate between anaclitic and introjective patients. Instead, they used prototype matching based on interviews, which were used for other purposes, thus potentially limiting their capacity to correctly identify these configurations, which can explain the unexpected results.

#### ***3.5.2.3 Introject affiliation.***

Klug et al. (2017) explored changes in introject affiliation, which refers to patients' representation of self and their behaviours towards that representation (Henry, 1996). The study found that changes in introject affiliation were positively associated with reduction in symptoms and interpersonal distress. The mediation analysis that was conducted provided no support for the role of introject affiliation as a mediator. The study's small sample might have been a significant limitation in this

regard.

#### **3.5.2.4 Mechanisms.**

Two studies (Bond & Perry, 2004; Falkenstrom, 2007) reported findings in areas regarded as psychological mechanisms, due to their state-dependant activation in comparison to the more stable psychological structures discussed above. Bond and Perry (2004) explored the use of defence mechanisms and reported a positive association between increased adaptive defence style and reduction in symptoms. Falkenstrom (2007) identified themes regarding patients' changes after the termination of their therapy. The themes that were identified were then analysed in relation to outcome. Only the theme regarding the development and use of self-analytic skills was found to be associated with reduction in symptoms. The quality appraisal found several issues regarding Falkenstrom's (2007) study which included small sample size and risk to reliability as the analysis was completed by only one researcher. In addition, patients were recruited from the STOPPP research project. Differences were found between the two samples, as the sample used in Falkenstrom's (2007) study had better outcome in comparison to the STOPPP sample. Thus, it is possible the Falkenstrom's (2007) study investigated the more successful cases, and the cases of patients, who were more willing to participate in an additional study. Therefore, potentially forming bias.

#### **3.5.3 Therapeutic relationship.**

Four articles explored the relationship between outcome and the therapeutic relationship. The studies examined the therapeutic alliance, which was measured in all of the studies using a patient-rated questionnaire and, in two of the studies, also included a therapist-rated questionnaire. Two of the studies involved repeated measurements of the therapeutic alliance, while the other two measured it at either a

very late or a very early stage of treatment. One study also analysed patients' secure attachment to their therapists, as was observed in interviews conducted with the patients at the end of treatment.

#### ***3.5.3.1 Therapeutic alliance and change in outcome.***

The findings reported by the studies exploring the therapeutic alliance were contradictory and differed based on the outcome assessed (interpersonal or symptom distress), the type of process measures used (patient or therapist-rated), and the inclusion of patients' pre-treatment distress in their analysis.

Two studies (Lindgren et al., 2010; Solbakken et al., 2012) reported that they did not find an association between patient-rated alliance and symptom distress. One of the studies (Lindgren, 2010) reported a near significant positive association between patient-rated alliance and decrease in symptoms, however, this was lost when symptom distress level at intake was added to the model. While a clear effect with regards to change in symptom distress was not found, another study (Solbakken et al., 2012) reported a positive correlation between patient-rated alliance and reduction in interpersonal distress.

In contrast to these findings, Lindgren et al.'s (2010) study, which used therapist-rated measures of the alliance, reported an unexpected negative correlation between therapist-rated alliance and change in symptoms. When symptom distress at intake was added to the model, an interaction effect was found, as this association was only found for patients with high levels of symptom distress at intake.

The quality appraisal found that Solbakken et al.'s (2012) study was limited by lack of repeated measurements, as the alliance was measured after the third session (Solbakken et al., 2012). The lack of repeated measurements limited the capacity to

form an understanding of the alliance, as this construct is known to develop and change over the course of therapy.

#### ***3.5.3.2 Therapeutic alliance mediator hypothesis.***

Klug et al. (2012) examined the therapeutic alliance as a mediator. This hypothesis was not supported. Mediation analysis was limited by the study small sample size.

#### ***3.5.3.3 Secure attachment and change in outcome.***

Lilliengren et al. (2015) examined the security of patients' attachment to their therapists as the main process factor. The therapeutic alliance was also examined, however only in its secondary analysis. Both measures were assessed near the end of the therapy. They were examined regarding two periods of change: from intake to termination and from termination to end of follow-up (overall change was not examined). Secure attachment was found to be associated with symptom change and interpersonal distress from intake to termination. This effect persisted when the alliance was included in the model, while the alliance was not found to have a significant correlation with outcome in this model. However, neither secure attachment nor alliance were found to be associated with the change from termination to follow-up. The quality appraisal of this study raised questions regarding the validity of the construct of secure attachment, and specifically its discriminant validity in relation to the construct of therapeutic alliance. These concerns were further highlighted by the positive correlation ( $r = .47, p < .001$ ) between the two constructs that was found in that study.

#### **3.5.4 The therapeutic intervention.**

Seven studies in this review explored process factors relating to the therapeutic

intervention. They were grouped into the following categories:

#### ***3.5.4.1 Dose.***

Three studies (Huber et al., 2017; Lilliengreen et al., 2015; Lindgreen et al., 2010) included the therapy dose in their statistical analysis in addition to other process variables, such as working alliance, secure attachment to therapist, and personality functioning. None of these studies reported the therapy's dose to be predictive of outcome. Zimmermann et al. (2015) also examined differential treatment effectiveness between psychoanalysis, long-term psychodynamic therapy, and CBT, and found that dose was a differential mediator of effectiveness, as psychoanalysis provided greater dose which in turn resulted in better outcome. However, this relationship was only found at the end of treatment and not at the end of the follow-up.

#### ***3.5.4.2 Therapy model.***

Five studies included the model of therapy (psychoanalyses, psychoanalytic therapy, and psychodynamic therapy) in their process-outcome analysis. These studies differentiated therapies based on extrinsic criteria such as the length of treatment, frequency of sessions, and therapists' self-identification and qualifications. All of the studies reported that psychoanalysis was considerably longer and included more frequent sessions than psychodynamic therapy.

##### ***3.5.4.2.1 Therapy model effects on outcome.***

Two studies (Huber et al., 2013; Sandell et al., 2000) reported that psychoanalysis and psychoanalytic therapy were superior in their effectiveness in comparison to psychodynamic therapy with regards to the reduction of symptom distress. Only one of these studies explored change in interpersonal distress and reported no differences between the therapies.

#### *3.5.4.2.2 Differences between the models related to outcome change.*

Four studies explored the manner in which process variables affected the outcome differently in psychoanalysis in comparison psychodynamic therapy. All of these studies but one reported that they could not identify significant findings with regards to change in introject affiliation, therapeutic alliance, overall structural changes and patients' post-treatment changes.

Only Zimmermann et al. (2015) reported a significant finding, stating that psychoanalytic technique was found to be a differential mediator with regards to reduction of depressive symptoms. The use of psychoanalytic technique was found to be more prominent in psychoanalysis and in turn was positively associated with symptom reduction. An exploratory analysis found that the following techniques were associated with change in outcome: discussion of sexual feelings and experiences, analysis of patients' dreams or fantasies, and retrieval or reconstruction of memories from infancy and childhood.

#### **3.5.5 Patients' pre-treatment characteristics.**

Three studies explored patients' pre-treatment characteristics as predictors of outcome.

##### ***3.5.5.1 Affect integration.***

Solbakken et al (2017) explored affect integration, which is defined as the capacity to consciously perceive, tolerate, reflect upon and communicate the experiences of basic affective activation (Monsen, Monsen, Solbakken, & Hansen, 2008; Solbakken, Hansen, Havik et al., 2011). It found a positive relationship between patients' pre-treatment impairment of affect integration and reduction of symptom and interpersonal distress.

### ***3.5.5.2 Level of personality organisation.***

Knekt et al. (2017) explored patients' pre-treatment level of personality organisation. An association to outcome was not found.

### ***3.5.5.3 Anaclitic and introjective configurations.***

Two studies (Werbart & Forsström, 2014; Werbart, Alan, Diedrichs, 2017) explored patients anaclitic and introjective configurations at baseline. An association to outcome was not found. Both studies had a very small sample size.

## **4. Discussion**

The main aim of this review was to identify the process factors associated with outcome and the nature of the relationship between the two in long-term psychoanalytic and psychodynamic therapies. An additional aim was to appraise the quality of these studies. Based on the inclusion criteria, 16 studies were identified and included in this review. Overall, they examined 18 process factors. Out of the 18 only 12 factors were found to be associated with treatment outcome. These factors corresponded to the following three areas:

### **4.1 Therapists' Self-Identified Characteristics and Attitudes**

The review found that therapists' views of themselves as supportive and kind were associated with a reduction in patients' symptoms. This finding was also reported in Berghout and Zevalink's (2011) study of long-term therapies. Similar findings were also reported in short-term psychodynamic therapies, as therapists' general affiliative, warm and caring interpersonal stance predicted better outcome for their patients (Coady, 1991; Najavits & Strupp, 1994; Svartberg & Stiles, 1992). Therapists' views resonate with (as they are potentially informed by) psychoanalytic and psychodynamic theories, which emphasise the supportive stance of the therapist.



Examples of this can be found in theories regarding containment (Bion, 1962), holding (Winnicott, 1960), and the internalised positive experiences formed by the “positive repetitions” between the patient and the therapist (Pfeffer, 1980).

The studies in this review did not provide for exploration of the theoretical underpinning of therapists’ self-views, their manifestation in therapy, nor did they discern whether these factors moderated or mediated the therapies’ outcome. This is perhaps due to fact that these studies were mostly exploratory in nature and had general research aims. The exception to that is Nissen-Lie et al.’s (2013) study, which was the only study that had theoretically informed research questions and specific hypotheses.

As such, these findings have limited clinical and theoretical implications, as also acknowledged by the authors of these studies. Further research is required in order to understand the manner in which therapists’ self-reports manifest and affect the therapy<sup>2</sup>. Comparable conclusions have also been shared by Lingiardi, Muzi, Tanzilli and Carone (2018) in their review of therapists’ subjective variables and their effects on outcome in psychodynamic therapies. Similarly, they also suggested that focusing solely on the therapists’ variables has limited value without the understanding of how these variables shape their interaction with patients.

#### **4.2 Changes in Patients’ Structural Configurations**

The review identified that changes in overall personality configuration, introject affiliation, and defence use all predicted outcome. These findings supported the theories which conceptualised these constructs as well as the existing research which examined them. Examples of this include: Huber et al.’s (2017) findings

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<sup>2</sup> Nissen-Lie et al.’s (2013) findings regarding therapists’ views of themselves as having advanced relational skills are especially interesting in this regard, as they demonstrate that therapists are biased in their self-evaluations.

regarding improvement in overall personality configuration and its positive association with reduction in symptoms supported its theoretical conceptualisation by Wallerstein (1991) and was similarly reported in two studies of long-term therapies (Grande et al., 2009<sup>3</sup>; Rudolf et al., 2012<sup>4</sup>); Klug et al.'s (2016) findings regarding improvement in introject affiliation and its positive association with reduction in symptoms supported its conceptualisation by Jacobson (1964) and was also found in studies of short-term therapies (Henry, Schacht, & Strupp, 1990; Quintana & Meara 1990); Bond and Perry's (2005) findings regarding the positive association between maturation of defences and improvement in outcome were shared by studies of both short-term (Akkerman, Lewin & Carr, 1999; Hersoug, Sexton & Hoglend, 2002; Johansen, Krebs, Svartberg, Stiels & Holen, 2011) and long-term therapies (Perry & Bond, 2012<sup>5</sup>).

However, two of the studies also provided findings which did not align with other studies in the literature: Klug et al.'s (2017) findings did not support the theory that changes in introject affiliation mediated the outcome (Kernberg, 1991, 1999; Moore & Fine, 1990); Werbart and Forsström's (2014) unexpected finding of the negative association between improved anaclitic-introjective balance and reduction in symptoms contradicted its related theory and previous findings (Blatt & Auerbach, 2003; Blatt, Besser, & Ford, 2007; Blatt, Ford, Berman, Cook, & Meyer, 1988). As identified in the quality appraisal and as acknowledged by the authors of both these studies, it is possible that these unexpected findings are due to the studies' small sample size, and in the case of Werbart and Forsström's (2014) study also due to the limitations regarding the process measures.

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<sup>3</sup> Study excluded due to outcome at post-treatment follow-up being measured retrospectively.

<sup>4</sup> Study excluded due to not being in English.

<sup>5</sup> Study excluded due to examining incomplete therapies.

Overall, the findings provided some evidence for the importance of the relationship between internal structural changes and therapy outcome in long-term psychotherapy (Grande et al., 2009). However, they do not shed light onto the nature of that relationship due to their small sample size and due their design, which does not enable to investigate these factors as mediators of outcome, despite being theorised as such.

### **4.3 The Therapeutic Technique**

Zimmermann et al. (2015) reported the unique finding that psychoanalytic technique (e.g., the therapist's neutral stance, the discussion of sexual issues, focus on early memories) differentially mediated the outcome for psychoanalytic therapy and not for psychodynamic therapy. It should be stated that this was the only factor in this review that was identified as a mediator.

### **4.4 Overview**

This systematic review identified process factors associated with outcome of long-term psychoanalytic and psychodynamic therapies. In most studies, findings did not provide additional information beyond the above associations. Thus, the studies in this review did not provide a better understanding of how and why long-term psychoanalytic and psychodynamic therapies work. It could be argued that this limitation was due to the studies overall low quality, which was attributed to two main factors: risks to internal validity and study design.

All of the included studies suffered from methodological limitations to different extents. As highlighted in the quality assessment carried out, most of the studies were of low quality mostly due to lack of measures taken to reduce the risk of bias in their investigations (e.g., lack of a control/comparison group, treatment

integrity checks, blind outcome assessors and others). This resulted in overall low internal validity, which hindered the ability to rely on their conclusions, as the associations they reported could be attributed to many possible confounding factors. Almost all of the studies acknowledged their significant limitations with regards to internal validity, which they attributed to the fact that they were conducted in a naturalistic setting. They highlighted that this means they had good external validity, however, this does not deflect from the appraisal of the quality of their evidence as weak.

Another methodological limitation shared by most studies was their low power, which could explain the lack of associations found between some of the process factors and outcome. For example, the therapeutic relationship, which was reported in the literature to have a robust association with outcome (e.g. Martin, Garske, & Davis, 2000; Wampold, 2001; Horvath, Del Re, Flückiger, Symonds, 2011; Lambert & Barley, 2011; Flückiger, Del Re, Wampold, Symonds & Horvath, 2012) was not found to be associated with outcome by the studies in this review. Another example is therapeutic dose, which has also been found to be associated with outcome (Hansen, Lambert & Forman, 2002; Lambert & Ogles, 2004). This association was not found by the studies in this review. This is perhaps to be expected, as the dose-response model suggests a negatively accelerated relationship, which would thus require a large sample size to identify. It is important to note, however, that the lack of reported associations does not equate to evidence for no association. These findings suggest that further research is needed to establish their role in long-term psychoanalytic and psychodynamic therapies.

All of the studies in this review provided findings regarding the association between process factors and outcome, which align with the existing findings in the

literature. Thus, their main value is that they suggest that these associations also exist in long-term therapies and/or are sustained after the completion of treatment. It is interesting to discuss in this regard Luborsky et al.'s (1971) review of process factors associated with outcome, as despite more than 40 years between that review and the present one, they share many similarities. Both reported that the studies they included examined similar areas, shared similar findings (e.g., therapists' self-views, defence use and others) and demonstrated similar methodological limitations. This is perhaps unexpected considering that as stated earlier, recent years have seen an increase in the sophistication of process-outcome research of psychoanalytic and psychodynamic therapies (Minges, Solomonov & Barber, 2017). However, this review suggests that this trend is seemingly mostly relevant to short-to-moderate length therapies. This, as only the three MPS studies in this review had a study design allowing for the investigation of the process factors as mediators. As a result, all but one of the studies in this review, did not provide findings which further the understanding of the mechanisms long-term psychoanalytic and psychodynamic therapeutic.

The reasons for this seemingly limited progress are unclear. One possible reason potentially relates to the high variability of the process measures used by the studies in this review and the variety of factors that they aimed to explore. It appears that this variability reflects the existing pluralism and fragmentation within the psychoanalytic and psychodynamic field (Fonagy, 2000; Grünbaum, 2001). This, as factors and their related measures were developed and used to examine specific theories and constructs in a manner that eventually does not amount to a solid and broad knowledgebase. For example, Lilliengren et al. (2015) and Solbakken et al. (2017) explored attachment to therapist and affect integration respectively, two constructs which have little support in the wider literature and which are not clearly

distinct from other similar constructs. Similarly, the overlap between the different types of structural changes identified in this review (i.e., level of personality organisation, introject affiliation and anaclitic-introjective) is unclear, and thus hinders the ability to draw more generalised conclusions from these studies, which could facilitate a joint rather a fragmented theoretical discussion.

#### **4.5 Implications for Clinical Practice**

The finding in this review that holds the most value to clinical practice is that of Zimmermann et al. (2015) regarding the use of psychoanalytic technique and its mediation of outcome. In addition, an exploratory analysis in that study also identified the specific components which potentially contribute to patients' improvement, which were: discussion of sexual issues, dreams, and early memories.

The implications of other factors are less clear, as less is known about their relationship with outcome. However, it appears that structural changes, whether with regards to defence, introject affiliation, general level of personality organisation, or patients' developed analytical skills, predict outcome. Thus, these results indicate that therapy might facilitate long-term reduction of symptoms by focusing on inducing these structural changes, as has been long suggested in psychoanalytic theory (Grande et al., 2009). Similarly, as therapists' views on kindness as a curative factor were found to predict better outcome, it is perhaps possible that therapists' reflection and adjustment of their views might also result in better outcome.

#### **4.6 Recommendations for Future Research**

This review highlights the need to develop a better understanding of the factors associated with outcome in long-term psychoanalytic and psychodynamic therapies. This, by conducting process-outcome studies using a more sophisticated design and

by addressing the many methodological limitations that affected the studies in this review. As such, future research would benefit from:

1. Adopting an RCT study design to increase internal validity;
2. Increasing statistical validity by including a greater number of participants;
3. Conducting repeat measurements of process and outcome variables;
4. Conducting mediation analysis;
5. Examining other well established and researched process variables (such as insight, transference interpretation, reflective functioning). This, in order to facilitate a more coherent and joint discourse within the field.
6. Forming research questions based on the psychoanalytic theory and constructs.

Many of these recommendations are already being applied in more recent studies of psychoanalysis and long-term psychodynamic therapies. For example, they are applied in the following three studies: the Tavistock Adult Depression study (TADS) (Taylor, 2015); the German Die Langzeittherapie bei chronischen Depressionen Study (LAC) (Leuzinger-Bohleber, Kallenbach & Schoett, 2016); and, the Anxiety and Personality Disorders (APD) study (Benecke et al., 2016). All of these studies have an RCT design, repeated measurements, and include a lengthy follow-up period.

#### **4.7 Limitations**

This review has several limitations.

First, as discussed in the introduction, the review did not make a distinction between different therapy models (i.e., psychoanalysis, psychoanalytic therapy and psychodynamic therapy) when discussing the findings of the studies included in this review. As such, it is possible the factors identified in this review are only relevant to certain long-term therapy models and not to all long-term psychanalytic and

psychodynamic therapies.

Second, Leichsenring et al.'s (2013) definition of long-term therapies as consisting of a minimum of 50 sessions and a duration of at least one year was used. However, there is no consensus currently, and other definitions of long-term therapy do exist (e.g., Smit et al., 2012). In addition, this definition has been considered as arbitrary and dependant on a specific context, in the case of this review, the context of public mental health services provided in the UK. Thus, these findings are perhaps not generalizable to other contexts in which long-term therapies are defined differently.

Third, the review did not make distinctions based on the patients' diagnosis and severity. This was mostly due to the fact that the majority of the studies in the review did not make such distinctions, as their patients were seen for general difficulties. The exceptions to this were the MPS studies, which focused on the treatment of depression. Thus, it is possible that the findings of this review are not relevant to all diagnoses.

Fourth, this review was conducted by a single author. Thus, it carries an increased risk of bias.

Fifth, the quality appraisal checklist used in this review, while based on existing quality appraisal tools, was specifically adapted for the purpose of this review of assessing the quality of process-outcome studies. As such, the checklist is not standardised, validated, nor used by any other reviews. The decision to specifically adapt a checklist was made due to a lack of "gold standard" of quality appraisal tools in general, as was concluded by Katrak, Bialocerkowski, Massy-Westropp, Kumar and Grimmer (2004), and as was highlighted specifically in the field of process-outcome research by Grant, Mayo-Wilson, Melendez-Torres and Montgomery (2013) and by Moore et al. (2015). Due to this lacuna, efforts have begun for the development of



suitable quality appraisal checklists (Montgomery et al., 2013), however, these were yet to be published at the time of completion of this review.

As such, some of the criteria included in the quality appraisal checklist in this review, are the subjects of a lack of consensus regarding their importance for process-outcome research. Chief among them is the criterion assessing whether a study followed an RCT design. This criterion has been debated by Marchal et al. (2013) and by Laurenceau, Hayes and Feldman (2007), who suggested that process-outcome studies based on RCTs tend to be of lower quality, due to RCTs tendency to exclude components such as repeated measurements, which are important for high quality process research. However, such limitations have been rejected by Moore et al. (2015), who highlighted RCT design's significant contribution to limiting bias in the exploration of the relationships between therapy related factors, such as process and outcome factors. This review supported this approach and thus included the RCT criteria in its checklist as well as the criteria cited by Laurenceau et al. (2007) to be often missing in process-outcome studies based on RCTs.

#### **4.8 Conclusions**

This review identified several process factors associated with long-term outcome of long-term psychoanalytic and psychodynamic therapies. These factors can be categorised into three areas: therapists self-identified characteristics and views; changes in patients' structural configurations; and, specific therapeutic techniques. Findings were hampered by the low quality of the studies and specifically their low internal validity. In addition, studies were limited by their design, as almost all of the studies omitted the components required for the investigation of the process factors as mediators. Considering these limitations, implications for clinical practice were mostly limited to the application of psychoanalytic technique. The rest of the findings

aligned with psychoanalytic theory and research, however, further and more sophisticated research is needed to develop a better understanding of their relationship with outcome. Recommendations for future research highlighted the need for study designs to include repeated measurements of process and outcome factors, comparison groups, and mediation analysis.

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## **Part 2: Empirical Paper**

### **Therapists' Views on the Challenges and Helpful Factors in Long-Term Psychoanalytic Therapy for Treatment-Resistant Depression**

## Abstract

**Background:** The Tavistock Adult Depression Study (TADS) demonstrated that long-term psychoanalytic therapy is more effective for Treatment-Resistant Depression (TRD) than treatment as usual, reporting that 30% of the patients reached partial remission. **Aim:** The aim of this study was to explore the experiences of the therapists, who provided TADS' psychoanalytic therapies, and in particular, their views on the challenges and helpful factors to the therapeutic process and its outcome. **Methods:** Thematic analysis was used to analyse 23 Private Theories Interviews, which were conducted with therapists who treated patients that experienced partial remission after completing the 18-month treatment. Partial remission was defined as a Hamilton Depression Rating Scale score  $< 12$ . Secondary exploratory analysis compared the emerging themes between two groups of patients based on their outcome at the end of a 42-month follow-up: patients who sustained their remission ( $n = 11$ ) and patients who did not ( $n = 12$ ). **Results:** The analysis identified two main themes as helpful: 'a containing and meaningful therapeutic relationship' and 'an effective psychoanalytic intervention'. Challenges were attributed to the effects of patients' pathology on their views of the therapy and on their therapists. Only 'insight gain' was found to be identified differently depending on patients' sustainment of remission. **Conclusion:** Establishing the therapeutic relationship through effective containment of patients over time was highlighted as a priority, as it enabled therapists to address patients' pathology more directly. A multitude of pathological mechanisms and techniques were used, supporting the view of TRD as a broad category of depression. The effects of patients' pathology interfered with the therapeutic efforts, and were mitigated by use of supervision and the support of others' involved in the patients' care. Further

research is needed to understand the mechanisms of establishing patients' sense of safety within the therapy and the effects of therapeutic changes on long-term outcome.

## 1. Introduction

Depression is considered one of the most debilitating psychological conditions due to its effects on individuals' quality of life and the societal costs involved in its care (WHO, 2014). Despite a growing evidence base for a wide range of psychological treatments currently administered in the UK, only a few are recommended by the NICE guidelines, most of which are short-term treatments (Cuijpers, Straten, Andersson & van Oppen, 2008; Garratt, Ingram, Rand & Sawalani, 2007; Lemmens et al., 2017; Lemmens, Müller, Arntz & Huibers, 2016; Velden et al., 2017). Not all patients benefit from these treatments, as it is estimated that between 30-50% of patients treated for depression do not respond to any intervention (Avenevoli, Swendsen, He, Burstein & Merikangas, 2015; Burcusa & Iacono, 2007; Mrazek et al., 2014). Approximately 1% of depressed patients experience recurrent episodes often lasting for more than two years. This group of patients are referred to as suffering from 'refractory', 'chronic', or 'Treatment-Resistant Depression' (TRD)<sup>6</sup>. These patients tend to experience more severe depressive episodes and utilise considerably more mental health resources in comparison to patients with less chronic forms of depression (Keller et al., 2000; Pomeroy & Ricketts, 1985).

Despite growing evidence supporting the effectiveness of psychoanalytic and psychodynamic therapies for these complex and chronic forms of depression (Fonagy, 2015; Fonagy, Rost et al., 2015; Town, Abbass, Stride & Bernier, 2017), this is not reflected in current treatment guidelines (APA, 2010; NICE, 2009). The guidelines recommend anti-depressants as first line treatment, and augmented treatment for non-responders by changing medication and/or by providing an adjunct psychological

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<sup>6</sup> The present study is primarily concerned with TRD; although there is a huge overlap of patients diagnosed with chronic and TRD (McPherson, Rost et al., 2018), the diagnosis of TRD has been considered the most inclusive of this type of depression taking into account the various failed treatment attempts (Ijaz et al., 2018).

intervention. The latter, still lacks robust evidence as to its effectiveness (Ijaz et al., 2018; McPherson et al., 2005; Pérez-Wehbe et al., 2014; Stimpson, Agrawal & Lewis 2002).

Two studies specifically provided evidence demonstrating the effectiveness of psychoanalytic and psychodynamic therapies for TRD: the first is the Halifax Depression Study (Town et al., 2017), which examined intensive short-term dynamic psychotherapy consisting of 20 sessions; the second is the Tavistock Adult Depression Study (TADS, Fonagy et al., 2015), which examined once-weekly psychoanalytic therapy provided for 18 months. A further study currently under way is the Langzeittherapie bei chronischen Depressionen Studie (LAC), which offers up to 80 sessions of psychoanalytic therapy for patients diagnosed with chronic depression (Beutel et al., 2012).

Both the Halifax and the TADS studies reported the statistical and clinical effectiveness of the treatment compared to treatment as usual (TAU) based on the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960). The authors of the Halifax study reported that by the end of the six-month follow-up, patients who received intensive short-term dynamic psychotherapy had benefited more from therapy in comparison to TAU (Cohen's  $d = 0.75$ ). In addition, these patients were more likely to reach partial remission than those who received TAU by the end of the follow-up period (48.0% vs. 18.5%). The TADS included an extensive two-year follow-up period after the completion of treatment. Partial remission was found to be significantly more likely among patients who received 18 months of psychoanalytic therapy in comparison to TAU (30.0% vs. 4.4%) at the end of the follow-up period.

Psychoanalytic and psychodynamic therapies aim to alleviate patients' distress and its related symptoms by enabling patients to gradually internalise a capacity that

allows them to reflect and relate differently to the disturbing factors within their life and their psyche, which contribute to the formation and the sustainment of their pathology (Taylor, Carlyle, McPherson, Rost, Thomas & Fonagy, 2012). These factors arise within the context of the therapeutic relationship, which with the help of the therapist, allows patients to explore them in a manner previously unavailable to them (Taylor, 2008). In order to: (a) allow the therapeutic relationship to be established for the purpose of such exploration; (b) to cover the wide extent of patients' "pathogenetic personal experiences, memories, feelings, beliefs and relationships" (Taylor et al., 2012, p. 2); and, (c) enable patients to firmly internalise the analytical capacity demonstrated by their therapists, considerable time is required and thus treatment needs to be long-term. Furthermore, there is growing evidence that this process is ongoing after therapy is finished. A number of studies of psychoanalytic therapies have found a so-called sleeper effect, i.e. the sustained and enhanced improvements over several years after treatment has ended (e.g., Abbass, Town, & Driessen, 2011; Falkenstrom, Grant, Broberg, & Sandell, 2007; Huber et al., 2012; Leichsenring & Rabung, 2011; Leuzinger-Bohleber, Stuhr, Rüger, & Beutel, 2003). Such findings have led to calls for a need to include a long-term follow-up in the studies of these therapies (Fonagy et al., 2015).

A multitude of psychoanalytic theories and conceptualisations of TRD exist in the literature (Arieti, 1976). Leuzinger-Bohleber (2015) and Bleichmar (2010, 2013) suggest that this does not only reflect the pluralism of theories within the field, but also mirrors the nature of TRD. According to both, TRD consists of different types of depression, which are formed and maintained by a multiplicity of pathways that are the product of complex interactions between the patient's psychological structures and his or her life events. In line with Freud's (1917) thinking, as expressed in his seminal

work “Mourning and Melancholia”, Leuzinger-Bohleber and Bleichmar suggest that TRD is in most cases the result of the patient’s response to an actual or perceived loss of an object. This response is informed by the object’s meaning for the patient and their conceptualisation of its loss. The loss, or the recurrence of similar circumstances in which the loss had occurred, elicit an emotion for the patient (typically anger, guilt, shame or anxiety) as well as processes which interfere with the acceptance of the object’s loss and with the establishment of new objects. This dynamic can explain the refractory nature of TRD. As such, Leuzinger-Bohleber and Bleichmar suggest that therapists’ understanding of these pathways and the adjustment of their intervention to address them for each individual, is a crucial component for the effectiveness of treatment, especially as focusing on the wrong mechanism can reinforce patients’ pathology.

An example of a pathological mechanism has been discussed by Steiner (1996), who also concurs that patients with TRD experience difficulties with acknowledging and mourning the loss of their objects. Steiner (1996) suggests that patients with TRD attempt to avoid the acknowledgment of their loss by resorting to powerful mechanisms of projective identification, which provides them with a sense of inseparableness from the object. This is resolved in the therapy in two stages: at the first stage, the therapist contains the patients’ projections, which enables the patient to internalise them in a manner that is less anxiety-provoking; at the second stage, the patients begin to develop their own sense of self-understanding, which enables them to relinquish their dependence on the therapist and mourn the end of their therapy. This allows patients to establish and accept their separateness from other objects in their lives and to mourn the loss of other objects.

Another source of knowledge regarding the treatment of TRD has been offered by the Austin Riggs Centre, which is an outpatient clinic offering services for the treatment of TRD, including individual four-times-weekly psychodynamic therapy (e.g., Fromm, 2006; Kayatekin & Plakun, 2009; Krikorian & Fowler, 2008; Muller, 2007; Pluken, 2003, 2006). Similar to Leuzinger-Bohleber (2015) and Bleichmar (2010, 2013), the therapists at the Austin Riggs Centre emphasise the importance of ongoing in-depth formulation throughout the treatment. Similar to Steiner (1996), they also strongly emphasise that patients with TRD use potent projective mechanisms, which require their therapists to reflect on the transference and countertransference, especially with regards to two challenging areas: (a) therapists' capacity to manage the negative transference frequently found in the treatment of TRD; and, (b) therapists' ability to detect and analyse potential enactments before being drawn into them. The clinicians at the Austin Riggs Centre suggest that it is therapists' difficulties with managing these enactments that often hinder or cause the treatments to result in failure (Pluken, 2003). For this reason, their treatment model includes working within a wider team and range of mental health services, which provide support for both the therapist and the patient.

The above theories are all based on therapists' individual accounts (Scott & DeRubeis, 2007). To the best of the author's knowledge, no systematic research has been carried out to date exploring therapists' experiences of working with patients with TRD, and specifically regarding therapists' views of the challenging and helpful factors to the therapeutic process and its outcome. A formal qualitative research approach would allow for an in-depth exploration of these factors while integrating the subjective experiences of many therapists (McLeod, 2013). This, in order generate new hypotheses which can enhance the knowledgebase (Wallerstein, 2009).



The present study explored therapists' views, which have been referred to as implicit or private theories by Sandler (1983) in his discussion of their merit in the psychoanalytic field. Sandler (1983) suggested that since the inception of psychoanalysis, its theory has been in a strained state of constant elaboration and expansion. This, as established theoretical concepts have been extended to the point of ambiguity, and as the introduction of new official or public theories, if not dismissed, resulted in the formation of different schools of thought within or outside the psychoanalytic field. Sandler (1983) suggested that this theoretical ambiguity and fragmentism does not hinder psychoanalysis but rather provides its therapists with crucial theoretical elasticity to manage the complex psychoanalytic work. This, as he suggested that rather than therapists being guided by complete "official" or public theories, they are guided by their subjective implicit or private theories. These are "theoretical segments" (Sandler, 1983) or "clusters of beliefs" (Hamilton, 1996) which are unconsciously formed in the therapists' mind and are informed by the therapists' clinical experience, knowledge of various public theories and personal intrapsychic processes. These segments can be held in an incomplete state and contradict one another, as they are used selectively and discretely by the therapists to guide their work (Canestri, Bohleber, Denis & Fonagy, 2006; Sandler, 1992).

Furthermore, it has been suggested that these private theories hold tremendous value for psychoanalytic theory as they often arise in an attempt to amend and expand the public theories. Thus, they have been suggested to be the source of many important theoretical developments in the field historically and their systematic research has been suggested to have the potential to advance the field (Canestri et al., 2006; Fonagy, 1982; Hamilton, 1996; Sandler, 1983; Sandler & Sandler, 1983; Stern, 2012; Werbart & Levander, 2006).

Sandler (1983) and Fonagy (2003) suggested that while therapists' private theories are a rich resource for knowledge, they are unfortunately often disregarded due to internal and external pressures on therapists to align with public theories. The pressures of these conflicts result in large parts of therapists' private theories being censored and thus located in the therapists' preconscious. In contrast, the segments that therapists hold consciously are either those which directly align with public theories or those which are processed to seemingly align with public theories by extending the theories' meaning, however, at the cost of ignoring the potentially valuable theoretical deviations.

As such, Sandler, Dreher and Drews (1991) suggested that the role of the researcher of private theories is twofold. The first, is to conduct interviews to elicit the private theories in a manner which relieves the therapists' tension to follow a public theory and allows greater preconscious components to emerge. This, by refraining from using a theoretical framework to guide the interview and instead asking the therapists to choose and describe relevant illustrative episodes on their own accord. The second is to analyse the interviews initially by formulating therapists' reports in a theory free manner, and then by discussing the findings in a reflective manner, which considers the researcher's own knowledge of public theories and its censoring effects on the research. These principles have been applied in recent years in a series of studies exploring therapists' private theories (Philips, Werbart & Schubert, 2005; Werbart, von Below, Engqvist & Lind, 2018; Werbart & Levander, 2005, 2006).

The aim of the present study was to explore the therapists' private theories of the challenging and the helpful factors in psychoanalytic therapy carried out as part of the aforementioned TADS study. Specifically, the present study focused on the

successful cases, as their investigation can generate hypotheses regarding the challenges in therapy, as well as the helpful factors which can assist in overcoming these challenges (e.g., Henriksen, 2016; Werbart, Missios, Waldenström & Lilliengren, 2017).

In the context of TRD, a successful outcome is considered a long-term reduction in symptoms, due to the symptoms' debilitating effects on the patients' lives (Rush et al., 2005). The assessment of this outcome using standardised measures has been considered imperative for its research, due to therapists' difficulties with correctly evaluating therapies outcome (Hatfield, McCullough, Plucinski & Krieger, 2010; Walfish, McAlister, O'Donnell, & Lambert, 2012). Thus, a study exploring therapists' views in successful cases requires a design which consists of two methods: a qualitative method that enables exploration of therapists' subjective experience in great detail; and, a quantitative method that enables adequate identification of successful cases (e.g., Midgley, Ansaldo & Target, 2014; Stuhr, 2002; Tillman, Clemence & Stevens, 2011).

The present study aimed to: (1) identify the factors that therapists view as helpful and challenging in therapies of patients with TRD who experienced remission; and, (2) identify which of these factors might be potentially associated with patients' long-term remission.

## **2. Method**

### **2.1 Setting and Study Design**

The study uses data collected as part of the Tavistock Adult Depression Study (TADS, Fonagy et al., 2015) which was conducted by the Adult Department of the Tavistock clinic in London. The TADS was a randomised controlled trial investigating the effectiveness of long-term 18-month psychoanalytic therapy for the treatment of

TRD, compared to treatment as usual. Patients' outcome was measured using the HDRS, which has been widely used in research of depression and specifically TRD (Al-Harbi, 2012; Nezu, Ronan, Meadows & McClure, 2000). Measurements were completed at baseline and every six months until 30 months after the beginning of therapy (the planned overall length of therapy was 18 months). Additional and final assessment was completed 12 months later, i.e., 42 months after the beginning of therapy and two years after the therapy's planned completion. A full description of the trial's methodology can be found elsewhere (Taylor et al., 2012). The TADS and its derived studies were approved by the Institutional Review Board of NHS West Midlands Research Ethics Committee (MREC02/07/035) (see Appendix C).

A qualitative adjunct to the main outcome trial was introduced in 2009, where the patients and their corresponding therapists were interviewed before and after their treatment. The therapists were blind to their patients' outcome and ongoing engagement with the study after the termination of therapy. The interview carried out was the Private Theories Interview (PTI; Ginner, Werbart, Levander & Sahlberg, 2001), a semi-structured qualitative interview that aimed to elicit and explore the therapists' private theories of their patient's problem formulation, pathogenesis and ideas of cure and change by asking questions in an open manner akin to the approach of a "social anthropologist rather than that of a clinician" (Werbart & Levander, 2006, p. 112). Therapists were able to freely select the themes, illustrative episodes and clinical concepts with which they presented their understanding of the therapeutic process and its outcome. The PTI seeks to minimise possible interference with therapists' construction of meaning by refraining from framing the interviews within a specific theoretical framework or within the interviewer's own understanding.

The interviews were conducted by two senior researchers. As the qualitative adjunct was introduced at a later stage, a variable amount of time passed between the completion of a therapy and its related interview, in some cases a few years. All interviews were audio recorded and transcribed verbatim not by the author of the present study, with the exception of two interviews, which were transcribed by him. The data was analysed by utilising both the transcripts and the recordings.

## **2.2 Treatment**

The TADS treatment consisted of 18 months of weekly individual psychoanalytic therapy, amounting to approximately 60 sessions, each of a planned length of 50 minutes, although the mean number of sessions was 43.

A treatment manual was written for the purpose of the TADS (Taylor, 2015). It reviewed the general guidelines and theoretical framework of the conceptualisation and treatment of TRD. It identifies its approach as rooted in the theory and clinical practice that has developed organically in the past decades at the Tavistock clinic. This has been suggested to specifically influenced by the following theoreticians: Michael Balint, Melanie Klein, Wilfred Bion, Sandler Joseph, Ruth Riesenbergs-Malcolm and John Steiner.

According to the manual, the aim of the therapy is to allow patients to “gradually internalize a psychological capacity to relate to pathogenic personal experiences, memories, feelings, beliefs and relationships in a reflective, yet also more active, manner” (Taylor, 2015, p. 86). However, the manual does not prescribe the treatment and instead aims to establish a framework for therapists to rely on and embed themselves within, if needed. It also values and prioritises the therapist’s personal judgement and flexibility in response to the patient’s needs over adherence to the psychoanalytic principles and research requirements. In addition to the manual,

therapists were provided with regular fortnightly supervision workshops, in which they had the option to discuss their patients. Fidelity to the psychoanalytic treatment approach was assessed using the Psychotherapy Process Q-Sort (Jones, 2000) and was found to be good (Fonagy et al., 2015)

## **2.3 Participants**

### **2.3.1 The therapists**

The therapy in TADS was provided by 22 qualified and experienced therapists with an average of 17.45 years of experience. Most therapists treated one or two patients, with the exception of four therapists who treated five patients each.

### **2.3.2 The patients**

The TADS' inclusion criteria required participants to be between 18-65 years of age, experiencing a current MDD episode as diagnosed by the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I; First, 1997), which had persisted for at least two years, and scored 14 or above on the HDRS. In addition, participants had to have a history of at least two unsuccessful treatments, at least one of which being pharmacological. Participants were excluded if they: received psychodynamic therapy in the two years prior to the study; were diagnosed with psychotic or bipolar disorder; and, had a learning disability.

Sixty-seven participants were randomised into psychoanalytic therapy. Their baseline average HDRS score was 19.8 (SD = 5.1). For 51 patients (76%) an outcome measurement at the end of the two-year follow-up period was available. The average HDRS score at that time point was 15.44 (SD = 6.46).

The present study used Jacobson and Truax's (1991) criteria to determine whether patients experienced reliable clinically significant change from baseline to any point after the completion of treatment. The reliable change index was 4.69, which

was calculated using participants' baseline scores and the HDRS raters' intraclass correlation coefficient which was 0.89. Clinical change was defined as partial symptom remission, which in line with previous studies was defined as an HDRS score of 12 or less (Frank et al., 1999; Hollon et al., 2014). Interviews with therapists whose patients experienced reliable clinically significant change were included in the present study.

A total of 24 cases met these criteria, of which 23 were included in this study, as there was no option of conducting an interview with the therapist of one of these cases. Patients' baseline average HDRS score was 17.78 (SD = 4.7) and their average HDRS score at the end of the 42-month follow-up was 12.04 (SD = 4.43).

For the purpose of a secondary exploratory analysis, the 23 patients included in this study were divided into two subgroups: the first, of patients who experienced reliable clinically significant improvement from baseline to the end of the follow-up period; the second, of patients who did not experience a reliable clinical improvement from baseline to the end of the follow-up period, i.e., patients who experienced partial remission after the completion of their treatment, which was not sustained by the end of follow-up.

The first group included 11 patients with an average HDRS score of 19.27 (SD = 5.66) and an end of follow-up score of 8.36 (SD = 2.73). The latter group included 12 patients with an average HDRS score of 19.27 (SD = 5.66) and an end of follow-up score of 16.42 (SD = 3.28).

## **2.4 Interviews Analysis**

Twenty-three therapists' interviews were analysed using Thematic Analysis (TA; Braun & Clarke, 2006). This data analysis method allows for the identification of recurring themes in large data sets, while still preserving their richness and

complexity (Braun & Clarke, 2006). In addition, TA is a flexible qualitative analysis method as it does not require adopting a specific theoretical framework when analysing the data (Braun & Clarke, 2006).

The analysis was completed using the NVivo software (version 12; QSR International, 2018) and was based on the steps suggested by Braun and Clarke (2006):

1. All of the interviews' recordings were listened to and their transcripts were reviewed by the author in order to become familiarised with the data.
2. Initial codes (also referred to as 'nodes' in NVivo), which are the most basic segments of the semantic or latent units of text, were generated.
3. Potential themes were identified as part of an iterative process of reviewing the generated codes. Using the NVivo software, preliminary construction of meaning began by forming the relationship between the different themes and codes. This was achieved by defining parent and child nodes, which reflected the breadth and the specificity of each node, with parent nodes beginning to represent the emerging themes and their hierarchy.
4. The generated themes were reviewed in order to refine them and their relationship with one another. NVivo was particularly helpful as it reflected for each node or theme the number of interviews in which it appeared. In addition, themes were compared in order to ascertain their specificity and lack of considerable overlap. This was assessed using the NVivo query function, which compared the different nodes. At the end of this stage, the complete codebook, which contained all of the themes and their relationship was generated using NVivo. The interview transcripts were then reviewed again to ensure the trustworthiness of the analysis and the saturation of themes.



5. Each of the themes and their interview excerpts were reviewed in a final step in order to define and name the themes in a manner which reflected their essence. This was reviewed with the TADS' lead researcher.

## 2.5 Secondary Exploratory Analysis

After the completion of the TA, an exploratory comparison was carried out to identify which of the themes were associated with sustained long-term remission. The comparison was based on the subgroups identified among the patients, in relation to whether or not their improvements were sustained in the long-term. Each theme was analysed by comparing the accumulated number of cases that it appeared in between the groups using chi-square tests of independence.

## 3. Results

The thematic analysis identified five main themes regarding the challenging and the helpful factors to the therapeutic process and its outcome, each of which included several subthemes as summarised in Table 1. This summary describes the themes that were found and the number of cases that they appeared in. This is reported with regards to the whole sample of this study, as well as with regards to each of the subgroups identified in the secondary exploratory analysis, which was based on patients' sustainment of remission.

Table 1

### *The Themes Identified by the Thematic Analysis*

Themes	Patients who experienced partial remission post-therapy		Patients whose remission was sustained by the end of the follow-up		Patients whose remission was not sustained by the end of the follow-up	
	(n = 23)	%	(n=11)	%	(n=12)	%
3.1 Helpful Factors	23	100%	11	100%	12	100%
3.1.1 A containing and meaningful therapeutic relationship.	21	91%	11	100%	10	83%
3.1.1.1 Patients' experience of the relationship as safe, caring and understanding.	18	78%	9	82%	9	75%
3.1.1.1.1 The resiliency of the therapeutic relationship.	7	30%	3	27%	4	33%

3.1.1.1.2 External factors providing further containment and support for patients' engagement.	6	26%	3	27%	3	25%
3.1.1.2 Patients' emotional contact with their therapists.	6	26%	2	18%	4	33%
3.1.1.3 Personal based motivation for engagement in the therapeutic relationship.	7	30%	5	45%	2	17%
3.1.1.3.1 Patients' internal motivation for involved engagement with therapy.	5	22%	3	27%	2	17%
3.1.1.3.2 Therapists' positive response and motivation for engagement.	3	13%	2	18%	1	8%
3.1.2 An effective psychoanalytic intervention.	23	100%	11	100%	12	100%
3.1.2.1 The therapist's approach.	13	57%	4	36%	9	75%
3.1.2.1.1 Assertive, challenging, and not 'classically psychoanalytic'.	6	26%	1	9%	5	42%
3.1.2.1.2 Understanding and adjusting to patients' view of their therapists.	3	13%	1	9%	2	17%
3.1.2.1.3 Use of peer supervision.	3	13%	1	9%	2	17%
3.1.2.2 Multiplicity of techniques in addressing the mechanisms of the pathology.	14	61%	5	45%	9	75%
3.1.2.3 The therapy induced changes.	19	83%	8	73%	11	92%
3.1.2.3.1 Insight gain.	17	74%	6	55%	11	92%
3.1.2.3.2 Appreciation and internalisation of thoughtful psychological reflection and its expression.	9	39%	4	36%	5	42%
3.1.2.3.3 Changes in mental structures configurations.	6	26%	2	18%	4	33%
3.1.2.4 External events which informed and enhanced the therapeutic work.	8	35%	3	27%	5	42%
3.2 Challenging Factors	23	100%	11	100%	12	100%
3.2.1 Challenges in forming the therapy as a safe space of possible change.	22	96%	10	91%	12	100%
3.2.1.1 Negative effects of patients' pathology.	22	96%	10	91%	12	100%
3.2.1.1.1 Patients' experience of the therapy as threatening, unsafe, and careless	20	87%	10	91%	10	83%
3.2.1.1.2 Patients' depressive mechanism attacks on change.	8	35%	3	27%	5	42%
3.2.1.2 Therapists' deficiencies with containing and holding the patient.	5	22%	2	18%	3	25%
3.2.2 Challenges in forming an effective and meaningful working dynamic.	19	83%	8	73%	11	92%
3.2.2.1 Patient related factors.	14	61%	7	64%	7	58%
3.2.2.1.1 Patients' resistance and limitations of therapeutic discussion.	13	57%	6	55%	7	58%
3.2.2.1.2 Patients' difficulties with dynamic exploration.	4	17%	2	18%	2	17%
3.2.2.2 Therapist related factors.	13	57%	8	73%	5	42%
3.2.2.2.1 Therapists colluding and succumbing to patients' pathology.	9	39%	6	55%	3	25%
3.2.2.2.2 Therapists' difficulties with forming and understanding of their patients.	12	52%	7	64%	5	42%
3.2.2.3 Challenges stemming from therapy structure.	16	70%	6	55%	10	83%
3.2.2.3.1 Set limited amount of time for the therapy.	12	52%	4	36%	8	67%
3.2.2.3.2 Therapy frequency.	9	39%	4	36%	5	42%

The results of the analysis are presented below, focusing first on the helpful factors and later reviewing the challenging factors. The themes are presented by order of prominence in the dataset and are illustrated using quotes from the interviews. It should be stated that when therapists described their patients' difficulties they used terms such as 'pathology', 'disturbance', and 'dysfunction' interchangeably. Thus,

patients' difficulties will be referred to as 'patients' pathology' hereafter, as this was the most common term used by the therapists.

### **3.1 Helpful Factors**

Two main themes were identified as helpful factors: 'a containing and meaningful therapeutic relationship' and 'an effective psychoanalytic intervention'.

#### **3.1.1 A containing and meaningful therapeutic relationship.**

The analysis identified that the experience of the therapeutic relationship as containing and meaningful was helpful in almost all of the cases (21 out of 23, 91%). This experience was found to be informed by the following subthemes:

##### ***3.1.1.1 Patients' experience of the relationship as safe, caring, and understanding.***

The subtheme of patients' experience of the therapeutic relationship as safe, caring, and understanding was helpful in the majority of the cases (18 out of 23, 78%), and in some, was suggested to be crucial for patients' sustained engagement with the therapy. It was identified that this experience was formed by patients' perception of the therapist as a good object, which was attributed to the therapists' non-judgemental, caring, carefully listening, and understanding position. Patients' sense of containment was further enhanced by the structure of the therapy, which provided them with a sense of reliability and consistency.

*"I made a link of this power of this internal figure really judging her [...] and makes her feel that there is nothing good about her. [...] I made that link with her and she felt very very understood by that and I could see that she immediately gained a kind of respect for me that I could understand her dark state of mind basically." [P600]*

*“I think having some stability, and regularity, in the week, and a woman, who was, interested in him, and who listened to him, and who was tolerant, helped him.” [P299]*

#### *3.1.1.1.1 The resiliency and safeness of the therapeutic relationship.*

In seven of the cases (30%) patients' sense of the therapeutic relationship as safe was linked to their experience of it as resilient. Time was considered as an especially important aspect in this regard, as the sense of resiliency was gradually established by repeated demonstrations of the therapeutic relationship's survivability. For most of these patients, this was suggested to be highly important due to their anxieties regarding the possibility of the relationship's demise and specifically their rejection by their therapists. For some of the patients, these anxieties were exacerbated by their attacks on the therapist and on the therapy, which were followed by fears of retaliation. For others, these anxieties were rooted in their negative perceptions of themselves. Therapists suggested that they were able to maintain the relationship's resiliency effectively by refraining from retaliating against the patients' attacks and by proactively amending the impact of these attacks when needed.

*“To go back to the question what helped. Well the fact that we survived it, from the beginning to end. that... you know I hadn't actually rejected her, turned on her, sent her away... [...] I think it was important. You know, I'd seen these, other aspects of her, and that I didn't seem... she couldn't quite believe it, but I wasn't repulsed by it, and I could still bear to be with her. So I think that helped.” [P384]*

*“Tolerating her acting out and still being there, rather than getting retaliatory. So when she would stop attending, or become dismissive and contemptuous, or very sort of grandiose, you know, having me talk to her about it but not withdrawing from her. I think those sorts of things were quite new for her.” [P251]*

The resiliency was also linked to the therapeutic relationship’s ability to be well-rounded, i.e., its ability to sustain expressions of negative views as well as positive from both the therapist and the patient. This was considered important as it also reduced the risk of idealising defence mechanism being activated, which could limit the therapeutic contact and maintain patients’ anxieties.

*“instead of an idealized, cuddly, yummy, mummy, sort of, thing, that he could merge with... I had become somebody separate and different who could say to him, you know, ‘you’re a, nasty little shit.’ And at the same time be available to help him and not reject him, just because he’s a nasty little shit. So, that was helpful.” [P150]*

#### *3.1.1.1.2 External factors providing further containment and support for patients’ engagement.*

In six of the cases (26%) it was found that patients needed the support of external factors to continue their engagement with therapy. These factors included the study’s setting, the admin and research personnel, adjunct psychological support interventions, and the patients’ GPs. For several of the patients, these factors were considered as crucial for their engagement, as these personnel encouraged patients to resume therapy and motivated them to repair the therapeutic ruptures. The analysis suggested that these factors effectively provided additional containment, which was

necessary for patients with significant difficulties of feeling safe within the therapeutic relationship.

*“He would really feel I was against him [...]. The fact that there were other people for him to go to, and talk with, and he felt cared for by, was an essential to the treatment. I wouldn’t have been able to treat him, without the support of the research arm of the study. [...] He didn’t feel you’re just doing research - you’re interested in him [...]. It’s what he needed as a child. He needed two parents, not one.” [P126]*

### **3.1.1.2 Patients’ emotional contact with their therapists.**

In six of the cases (26%) it was found that the formation of an emotional contact between the patient and the therapist, as part of a “real” relationship between the two, was helpful and was seen as especially important for this group of patients. Emotional contact was conceptualised as patients’ experience of a significant emotional response to their therapists and the subsequent acknowledgement of this response by the therapists. This contact provided patients with a sense of hope and a motivation for change, as during these moments of contact, patients retired the pathological mechanisms, which until then limited their engagement, and as such they were able to be nourished by the therapy.

*“I had to make contact with him somehow, emotional contact. And at first the only way I could make emotional contact with him was by stinging him into a kind of ‘well you don’t help, you don’t give me any solutions to my problems’. And then I felt we were in contact.*

*He was annoyed with me and I could acknowledge that and we could somehow had a basis on which to proceed.” [P147]*

### ***3.1.1.3 Personal based motivation for engagement in the therapeutic relationship.***

In seven of the cases (30%) it was found that the therapeutic relationship was positively charged by the patients and/or the therapists increased motivation.

#### ***3.1.1.3.1 Patients’ internal motivation for involved engagement with therapy.***

In four of the cases, it was found that patients (17%) were perceived as highly motivated to engage in the therapy. Overall, these patients were described as having the capacity, and more importantly the “will”, to engage with the therapy rather than “fight it”: a stance which therapists attributed to many of the patients in the study. Patients were motivated by a variety of factors, including their participation in the study, which was perceived as helping the “greater good”.

*“I think she really had a need to use it, and a capacity to use it. And that’s why she was helped. That she didn’t waste a lot of energy on fighting it. [...] I think she doesn’t fight it in the way many patients do. And many, I think, of the patients in this research do” [P370]*

#### ***3.1.1.3.2 Therapists’ positive response and motivation for engagement.***

In three of the cases (13%) the analysis found that the therapists experienced a positive response, which increased their dedication to the therapy. This was due to their appreciation of their patients’ engagement with the therapy, thus forming a positive cycle of reinforcement.

*“I felt that I had kind of a, almost, I would say, personal interest (chuckles) kind of, actually try to help him to survive and to develop.*

*[...] I thought that he, was someone who actually managed to grasp probably the first opportunities he ever had to think about himself, and manage really to pull himself, and to develop reluctantly, where are we going, in a short period of time. I kind of feel some, some respect as he, that he managed to achieve during short speed and time.” [P380]*

### **3.1.2 An effective psychoanalytic intervention.**

The analysis identified that the theme of the therapy as consisting of an effective psychoanalytic intervention was helpful to all of the patients. This was related to the following subthemes:

#### **3.1.2.1 The therapist approach.**

##### *3.1.2.1.1 Assertive, challenging, and not ‘classically psychoanalytic’.*

In six of the cases (26%) it emerged that therapists felt the need to adopt a more assertive approach with their patients, while still maintaining a containing and a non-judgemental stance. In these cases, it was found that therapists presented their views, especially with regards to their patients’ pathology, in a direct, explicit, and challenging manner, especially when differences in opinions between them and their patients existed. In two of the cases this was conceptualised by the therapists as a deviation from the ‘classically psychoanalytic’ approach, as they were less reliant on a removed reflective position. This approach was partly informed by the therapists’ personal style, but mostly informed by the patients’ needs, as it: increased patients’ engagement with the therapy; developed patients’ capacity to engage in such complex interpersonal interactions; and, formed the therapists as a separate object. This approach was also considered as necessary with high-risk patients, as therapists had to address and manage risks in a direct and proactive manner.



*“there was a particularly traumatic incident, I think for both me and the patient. where he... he left the session and went to the train station and th- had-had thoughts of throwing himself in front of a train. And, came very close to acting on these thoughts. [...] I think that incident, kind of gave me quite a jolt. [...] I thought of it as a kind of wake up call. I realised I had to be more assertive with this patient... and address his contempt, more actively.” [P329]*

#### *3.1.2.1.2 Understanding and adjusting to patients’ view of their therapists.*

In three the of the cases (13%) a helpful theme that was found was therapists’ adjustment of their focus on how they were perceived by their patients. This was considered as necessary, as therapists often found that their therapeutic efforts were aligned with patients’ harsh internal objects. This, resulting in the therapists and the therapy in being perceived as attacking and dangerous. In all of the cases this was linked to early traumas experienced by the patients.

*“You can't assume you're an object who is good to the patient; you've got to try and understand what kind of object you are for the patient. And the closest I came to was that I'm always a very disturbing person, abusive objective, an object who's going to get in and do something to her, more complex. [...] I would focus much more on what kind of object I am for her.” [P185]*

#### *3.1.2.1.3 Use of peer supervision.*

In three of the cases (13%) peer supervision was found helpful for the therapists. This, as it alerted the therapists to difficulties in the therapeutic process that

they were unaware of, as well as provided them with support in their work with high-risk patients.

*“Having the support of the team, which I think was important for me to kind of, to feel that I had support of the team, as he, attempted suicide, kind of seriously, following his preliminary meeting with me, so this helped me kind of to feel that I can continue with him.”*

*[P380]*

### ***3.1.2.2 Multiplicity of techniques in addressing the mechanisms of the pathology.***

The analysis identified that a main subtheme that helped to facilitate an effective psychoanalytic intervention, was therapists’ ability to identify their patients’ pathological mechanisms and apply an appropriate technique for them, as was the case with 14 of the patients (60%). As such, a wide range of techniques were used by the therapists, such as: interpreting patients’ internal processes and pathological mechanisms; modelling adaptive capacities; eliciting and reflecting on patients’ avoided issues; recovering meaningful memories; solidifying and enriching patients’ life narratives; resisting merger attempts; mobilising the patients to act; and, others. Overall, therapists demonstrated a multitude of formulations of patients’ pathology and a wide repertoire of psychoanalytic techniques.

*“[The patient] moved from being, really, a hopeless passive derelict, to being somebody who could take the initiative in a limited way. [...] He did at one point actually assert himself [...] and I observed with him that in standing his ground and not being pushed around, he had quite a lot of training with me. [...] So to get to*

*mobilize some of the anger and stand up for himself, or even just resist something when someone was trying to push him around, was a big change for him.” [P147]*

*“He sort of, lived in his own mind with this tangential relationship with external reality, [...] I think, just introducing the idea of somebody who could have a sort of view of him, which was helpful and elaborate, and actually enabled him to think a bit more in a reality-based way, trying to support a more healthy state of his mind. He was able to see himself as he was, and external reality. That freed him up a bit and he was able to work.” [P126]*

*“He would be constantly trying to get me to join with him and then there would be the merger happening. and so it was a constant repetition of me pulling away from that, being able to be separate and different, and him being able to cope with that.” [P150]*

### **3.1.2.3 The therapy induced changes.**

The analysis found that three types of therapy-induced changes were considered as helpful to the therapeutic process and its outcome, in almost all of the cases (20 out of 23 of the patients, 87%),

#### **3.1.2.3.1 Insight gain.**

The most common helpful change (20 out of 23 of the patients, 87%) found was patients’ gain of insight. Insight was developed by what was referred to as the typical mode of the psychoanalytic “work”, i.e., reflective discussion of patients’ experiences, therapists’ provision of interpretations, and, most importantly, patients’ meaningful engagement with this process. The latter was identified as important, as in

many of the cases, therapists suggested that this signified a positive shift in the therapies, as initially patients would dismiss their interpretations in a manner which rendered them ineffective.

Insight about patients' internal world was developed, specifically in relation to their pathological mechanisms, and the manner in which they informed their interactions with themselves and others. It was identified that this did not always result in behavioural changes. However, it provided patients with understanding and awareness of the warning signs preceding these maladaptive patterns. Insight gain also resulted in greater coherence for the patients, which allowed them to think in a clearer, less concrete, and more creative manner, which was helpful for the dynamic exploration.

A prominent area of insight that should be noted was patients' difficulties with separation. This appeared to be an important area, as patients were highly reactive to moments of separation in the therapy. In most cases, this was eventually resolved by "working through" these moments, i.e., developing patients' insight regarding their sensitivity to loss and separation.

*"I think to, for example, to help him to see some melancholic mechanisms fairly early on, this brought a huge immediate relief actually for him, from a very, very, kind of deadly identification, melancholic identification, which helped him kind of gain some capacity actually to feel that he can begin to hold onto life now that he's not Primo Levi." [P380]*

*"I thought that the, the understanding of, let's call it, the depressed state of mind, with these dead things... I thought that that was*

*helpful, in enabling her to become more active, and more resourceful and initiative.” [P140]*

#### *3.1.2.3.2 Appreciation and internalisation of thoughtful psychological reflection and its expression.*

In seven of the cases (30%) patients’ increased appreciation of the dynamic exploration modelled by their therapists and its subsequent internalisation, was identified as a helpful theme. This also resulted in an increase in patients’ psychological-mindedness, and specifically with regards to their own sense of being a “psychological entity”, i.e., having an active mind and psyche that could be thought of and explored for their benefit.

*“I thought he actually began to use his mind or to recognise that he had a mind during the treatment, and that it was a revelation to him. [...] It’s why he started to get better, in treatment, because here was somebody, sitting down with him, regularly, predictably, listening to him, and thinking about using their mind on his state and his difficulties. And that allowed him to, to realise, allowed him to internalise something. That actually, if there’s a problem, you can do something about it, or you can at least understand what’s going on inside you.” [P169]*

*“One of the real changes for me, in the treatment was that she understood that what she thought was physical illness was actually depression. In other words, she was able to mentalise something which had previously been only concretely thought about.” [P251]*

#### *3.1.2.3.3 Changes in mental structures configurations.*

In six of the cases (26%) changes in the patients' mental structures and representations were found to be helpful. Changes included introduction of new types of objects and experiences for the patients, which they could then rely on for support and for greater effective functioning, such as for managing relationships. Changes also included modification of patients' relationships with their internal objects, either by modifying their potency or by realigning patients' identification with their internal objects. This could then increase the objects' supportiveness or alternatively decrease their negative effects on the patients. These changes were mostly achieved via the patients' experience of: (a) the therapeutic relationship as a living experience of two objects existing peacefully; and, (b) the therapist as a helpful, thoughtful, and good separate object. Another means of achieving change was by enriching the patients' object, specifically by retrieving segments of the them which had been obstructed and removed by the pathology.

*"I was able to become a different sort of object, to, erm... the objects that he had up till then in his mind, which was either somebody he merged with, or somebody who's attacking you. The thing that's changed, is that he now has... a living experience of a different kind of relationship. That's the only thing that's changed. So it's a resource that wasn't available to him before. [...] And I think it is the, erm... the development of this kind of internal object that will eventually lead him to be able to function, er... more successfully, in the outside world." [P150]*

#### **3.1.2.4 External events which informed and enhanced the therapeutic work.**

In eight of the cases (35%) it was found that patients experienced external events which were helpful. Three types were of events identified: the first were external events which provided the patients with tangible achievements. These reflected and cemented patients' progress in the therapy, as it required patients to apply the therapeutic changes in order to attain and sustain these achievements. These events were also experienced positively by the therapists, who actively encouraged and explicitly supported patients towards achieving these goals.

*"I think that starting to be a student made a big difference to him. 'cause, starting it was partly because, I'd been really trying to help him think about his situation and his life. And what he was going to do. But, when he came in and told me that he'd enrolled, I was really quite pleased." [P169]*

The second type were events that were suggested to have had a profound emotional impact on the patients, resulting in a change in their engagement with therapy. Therapists suggested that following these events, patients relinquished their typical defences in the session and allowed greater emotional contact and a more open and thoughtful discussion, which was maintained after these events.

*"There was one occasion when she came along here, and she sobbed, and sobbed, and sobbed, in a way that was most heart rending. It was to do with her finally realising that her marriage had ended. And, I have rarely seen, such kind of raw, agony if you like. I was thought it was a very different kind of contact, with what this place represented for her. And this much more complicated sort of,*

*hysterical, frigid way of relating. It was helpful to me to see that.*

*Because I felt I understood something more.” [P321]*

The third type of external events presented patients with information which modified their perceptions and beliefs. In several of the cases, patients’ observations of others provided them with new insights, which were elaborated upon in the therapy. In other cases, patients’ anxieties were significantly reduced once they were able to realise that the outcome they feared (often involving fears of rejection and annihilation) did not come to fruition. In most of these cases, patients were able to apply thoughtful reflection, which they seemingly acquired in therapy.

### **3.2 Challenging Factors**

Themes regarding the challenging factors in the therapy were identified in all of the cases. Two main themes emerged: (a) challenges in forming the therapy as a safe space of possible change; and, (b) challenges in forming an effective and meaningful working dynamic.

#### **3.2.1 Challenges in forming the therapy as a safe space of possible change.**

The main theme regarding the challenges in forming the therapy as a safe and hopeful endeavour of possible change was identified in all the cases but one (22 out of 23 patients, 96%). The analysis found that therapists most frequently attributed these challenges to the impact of the patients’ pathology, as this was identified in two subthemes, which were found in all cases but one (22 out of 23 patients, 96%). Only one subtheme was found that attributed these challenges to the therapists and it appeared in a much smaller number of cases (four out of 23, 17%):

##### ***3.2.1.1 Negative effects of patients’ pathology.***

*3.2.1.1.1 Patients’ experience of the therapy as threatening, unsafe, and careless.*



A main subtheme which was found in almost all of the cases (19 out of 23, 83%) was patients' difficulties with feeling safe in the therapeutic relationship. This was considered as the most significant challenge in the therapy, as it severely hindered or negated the possibility of forming a therapeutic alliance. In these cases, patients experienced intense and debilitating anxiety, due to their concerns about being in a position of vulnerability, from which they would be unable to recover. Specific anxieties involved fear of dependency, "malnourishment", "contamination", loss of control, and of "devastating" insight that might emerge in therapy. In most of the cases, these anxieties were identified as linked to traumatic early experiences, such as early separation, boundary collapse, external attacks, and a sense of deprivation.

As a result, patients were hypervigilant regarding signs of perceived threats from their therapists. This was especially prominent in moments of separation. Patients' hypervigilance resulted in a rigid and tenuous relationship, as patients often managed their sense of threat by limiting contact with their therapists. This was achieved in several ways, such as idealising the therapist, taking control over therapy, and "cutting off", at times to the extent of terminating the therapy. For several patients, the sense of threat also resulted in aggression and punitive behaviours towards their therapists. These responses exacerbated their difficulties of engagement, as their actions were followed by guilt and further anxiety due to fears of retaliation.

*"I became aware that I was a dangerous object for her. [...] I was always a potentially contaminating object for her so she couldn't, if she lost control and made herself vulnerable to me. [...] The rapport was full of dangers and full of I think something very linked to the abuse and something very disgusting, contaminating, boundaries collapsing. So I thought gosh, that's a difficult thing, it will take a*

*long, long time to make any contact, if we can make any contact.”*

*[P185]*

Patients’ difficulties with managing these anxieties were attributed to pathological mechanisms that prevented the formation of a stable good object, which patients could make use of. These mechanisms consistently undermined their good objects, and in some of the cases also morphed them into bad objects, for example, by realigning the therapists with these harsh internal objects. Thus, therapists were often perceived as another attacking and non-caring object, resulting in patients’ rejection of the therapists and their therapeutic efforts. In several of the cases, therapists questioned whether it was at all possible for these patients to form any positive representations of them, as the therapists were immediately identified with the patients’ bad objects in the transference.

*“The existence of a version of me inside him would be felt to be toxic and attacked. He would be assailed with thoughts about how I didn’t really care about him, and I couldn’t have really cared about him. And those thoughts would serve to undermine the, er, his link, with me.” [p150]*

*“You could see that she turned me into a monster, which she felt is just about to attack. The problem when you attack your object is that you attack your good objects also and this is the recipe for a depressed state of mind. And by the same token when she felt attacked she lost sense of all goodness of her.” [P600]*

*“[The therapy] lasted, for a while, and it broke down, as all his relationships breakdown, his good objects just turn bad like that,*

*they do something wrong they make a demand on him, they don't agree with him and, he's got to get away, and that eventually is what happened with me because he didn't complete the treatment."* [299]

Despite these significant challenges, patients continued to attend therapy due to their internal wishes to form a satisfying connection with a good object. While this sustained the therapy, it also resulted in patients' frustrations, as many of them shifted between wishes for a connection, while also defending or undermining it. This was not necessarily resolved by the end of the therapies, with therapists suggesting that more time was needed to address this.

*"He could begin a relationship, he could imagine the nourishment that might be derived from a relationship, but as he would get terribly worried that he was doing something wrong, or that he wasn't going to get what he needed, or I was thinking about a better patient for me, rather than him. He could never feel very secure. He would momentarily come to life. And make contact with me. And then he's- almost say, 'oh my god, what have I done' and close down. And so it was really hard to, establish what we would we describe as a sort of treatment alliance."* [P127]

#### *3.2.1.1.2 Patients' depressive mechanism attacks on change.*

In eight of the cases (35%) it was found that patients' depressive mechanisms attacked the possibility of positive change, resulting in a challenging sense of despair and hopelessness in the therapy. This was especially prominent following moments of meaningful contact and progress in the therapies, as they elicited a sense of hope which was soon after annihilated by the patients' attacks on self.

*“I used to feel upset that the force of the hostility, the negativity, the destructive nature was so powerful. And it made me aware of, you know maybe what really happens in, what underlies depression, is this enormous powerful destructiveness that, that just defeats everything. [...] His own internal destructive forces killed everything that was good, including the therapy, what I was doing for him.” [P314]*

*“Exactly as Freud described depression - a part of the self mercilessly attacks another part of the self, identified with the lost object. And he was a classic example of that cos his negativity, his destruction was all aimed at himself. It was a cycle in which he was the one that was actually making the attack on himself, removing himself from contact with anybody who would be able to offer him any help. And of course when he succeeded in attacking himself, then he could fall into quite a bleak state of mind. And that would be his experience of depression.” [P150]*

### **3.2.1.2 Therapists’ deficiencies with containing and holding the patient.**

In four of the cases (17%) it was found that therapists’ actions were potentially experienced as not containing by their patients, which hindered the therapy. Therapists were seemingly unable to hold their patients’ needs in mind for various reasons, such as preoccupation with personal matters or their own eagerness to delve into the therapy.

*“I said ‘It’s time you get on with some therapy’. And that, bingo. [laughs]. He feel I didn’t listen to him, see, so that was important. I*

*wasn't understanding from his point of view. [...] You know, me, in a hurry, to get him into therapy, when he wanted to sort of be able to assess who the hell this guy was. And he [claps hand] that was it. He was out. And I thought 'well that's it, he won't come back'."*  
*[P126]*

### **3.2.2 Challenges in forming an effective and meaningful working dynamic.**

A majority of the cases (19 out of 23, 83%) experienced challenges in establishing an effective working psychoanalytic dynamic, in which therapeutic meaning could be formed. Subthemes attributed to this were identified as related to the patients, therapists, and the structure of the therapy.

#### **3.2.2.1 Patient related factors.**

##### *3.2.2.1.1 Patients' resistance and limitations of therapeutic discussion*

In 13 of the cases (56%) it was found that patients exhibited resistance to the therapeutic efforts, which limited their engagement and the therapists' ability to facilitate a meaningful therapeutic discussion. Several of the patients exhibited active resistance, for example by dismissing or negating the therapists' interpretations, while others exhibited passive resistance, as they did not communicate any sense of engagement. Patients varied in the extent of their resistance, with some enabling a certain amount of effective therapeutic discussion before disengaging, mostly due to anxieties regarding intimacy and gain of insight.

*"He had quite good mind, if he ever chose to it, which he did not much, I mean he actively tried not to, because that meant the concrete lead would have cracked. But he could have been a very good chess player for instant. And he often, you know, I was about to make a therapeutic move on the chessboard and he would block*

*it, he'd see it coming and block it. And I thought 'Hmmm'. I described this process to him and he sort of grinned."* [P147]

*"The process was, that initially she would begin to reveal things. Particularly let's say, concerning her father and her mother. I would then see significance in this and she would deny the significance. 'How'd you get that, that's not connected with this, that's not connected with that.' So, and also that her times of depression and tearfulness were not connected with anything."* [P321]

#### *3.2.2.1.2 Patients' difficulties with dynamic exploration.*

In four of the cases (17%) it was found that patients had difficulties with dynamic exploration, which was at the core of the interventions provided. This was attributed to two main areas: patients' overall concreteness and lack of psychological-mindedness, which negated the notion that patients' are affected by their internal world; and, patients' perceived needs and expectations from the therapy, which seemingly did not correspond with psychoanalytic dynamic exploration, as patients sought interventions which provided a more explicit sense of support. These patients did not understand the aims and the mechanisms of the therapy, which enhanced their anxieties and resistance to it.

*"She wasn't someone who- for whom this model of treatment made sense [laughs] you know. I think she didn't, really didn't understand it. She would say she just doesn't get what it is I'm trying to do with her. And she was expecting to be told much more about, giving advice and, told, what to do [laughs]. To me it felt like if- we had the usual kind of process of assessment, we might not- even have*

*recommended psychoanalytic psychotherapy for this patient.*“

*[P255]*

### **3.2.2.2 Therapist related factors.**

#### *3.2.2.2.1 Therapists colluding and succumbing to patients' pathology.*

In nine of the cases (39%) therapists' accounts suggested that they “colluded” or succumbed to their patients' pathology, i.e., they were unable to forge alternatives to the pathologies that were recanted in the session. This occurred in two types of scenario: in the first, therapists identified with the patients' projections, and especially patients' hopelessness and despair; in the second, therapists “colluded” with the patients' pathological mechanisms and defences by not addressing them, despite being aware of them.

*“I suppose the whole situation that he presented with was depressing. So, you know, erm, if you think about the projection of depression into.. you know, the therapist, I think that worked quite well. I think he did make me feel depressed about him. Er.. and also depressed about, you know, what one could do for chronic depression. For patients who have been ill like this for so long.”*

*[P314]*

#### *3.2.2.2.2 Therapists' difficulties with formulating and understanding their patients.*

In 12 of the cases (52%) it was found that the therapists had difficulties with formulating and understanding their patients, at times referred to as “being at a complete loss”, which limited their ability to form and provide an effective intervention. Therapists had particular difficulties with identifying the active

ingredients in the therapies and with assessing patients' response to the intervention. These challenges were attributed to a wide variety of factors including: the therapy structure, patients' pathology and therapists' response to it.

*"We never quite got to the bottom, of what was going on. I- and other times I thought, I'm having the wool pulled over my eyes. [...] I don't know what's helped her, and what hasn't." [P384]*

*"I don't have a really coherent picture of.. erm.. the structure of his character, or mind. He was too... too evasive, and had too much of a, erm, er... an established way of presenting himself. Erm. For me to be able to.. easily, and in once a week, to get at what's inside that." [P169]*

*"Not enough, exploration had been done. [...] I've never formulated it, but now that we talk like this er, I've never really gone that far, do you see what I mean?" [P236]*

### **3.2.2.3 Challenges stemming from therapy structure.**

In 16 of the cases (70%) the challenges in the therapy were directly attributed to its pre-set structure, which consisted of 18 months of weekly sessions.

#### **3.2.2.3.1 Set limited amount of time for the therapy.**

In 12 of the cases (43%) therapist' accounts suggested that patients required more time (in some cases estimated to be in years) to allow long-term changes to take place. Time was considered of the essence, as it was required to foster a solid therapeutic relationship, and for the patients to firmly internalise good objects and insight. It was also suggested that the fact that the therapies' set amount of time was known to the patients from the onset of their therapies, hindered the therapies, as it



enhanced patients' anxieties about engaging with it due to being aware of its set ending.

*"It wasn't long enough. She took so long to get started. You know, it's, erm... Well, I hope it's given her something and set her off on the right road, but I think she needed a lot longer.. In terms of the sessions, and not the intensity. I think she could have done with a couple of more years of you know, just going, working through these problems, in transference, as they emerged. Without this tremendous pressure of time." [P251]*

*"Your question was about why is the progress lost. I think it has to do with the fact that the, if you like, the, the, the trauma is so early, um, that she, the, the, you could say the good object isn't firmly installed. When there's an absence there's then a very bad object she's left with. And because, I suppose, the, the... if you want to call it trauma, or the developmental difficulty lies so early I think, I think really she would have needed something longer term and more intensive to work [laughs] through that, mmm, and install something of a good object more firmly within herself, mmm." [P272]*

#### **3.2.2.3.2 Therapy frequency.**

In nine of the cases (39%) it was suggested that the therapy was hindered by its low frequency of once-a-week session, as it provided challenges for both the therapists and their patients. For the therapists, it hindered their ability develop a deep formulation of their patients. For the patients, the low frequency was insufficiently containing, leaving them feeling abandoned between the sessions. Greater frequency

was also considered as necessary to better consolidate the therapeutic changes, as these were often perceived as “lost” between the sessions.

*“Once a week, with a patient like that, it’s very flimsy, it’s a very.. we touch a little bit here and then basically. You can’t get a picture really.” [P236]*

*“He’d have an intense experience in the session, and then, nothing. So he felt abandoned, and betrayed, and I was off doing whatever he imagined I was off doing.” [P127]*

*“the patient would talk about how... feeling it was just too long from session to session, and partly that was a bit denigrating, but partly there was also some truth in it, and I thought actually it was for this man, to hold something real from week to week.” [P210]*

### **3.3 The Relationship Between the Themes**

The analysis revealed several links between the different themes that were found. In almost all of the cases, the therapeutic relationship and specifically patients’ feelings of safety and care within it as well as their belief in its therapeutic potential, were considered as the basis for the therapeutic intervention, both in the analyses of the helpful and the challenging factors. Establishing the therapeutic relationship was found to be challenged by three factors: (a) patients’ pathology, which undermined the therapists and the therapy’s representation as good and helpful; (b) therapists’ non-containing responses which directly reduced patients’ feelings of safety; (c) the therapy’s set limited amount of time which meant several of the patients were aware of and worried about its termination; and, (d) the therapy’s low frequency which left several patients feeling abandoned and uncared for between the sessions.

The effects of these challenges were reduced by helpful factors which included: (a) the resiliency of the relationship which was demonstrated over time; (b) therapists' engaged and caring approach; (c) external factors which enhanced patients' feelings of containment and support; and, (d) added motivation for engaging with relationship stemming from the patients and their therapists' personal reasons.

Feelings of safety within the relationship enabled moments of positive emotional contact between the therapists and their patients, which further enhanced patients' sense of care or safety within the relationship. In some cases, these moments of emotional contact were enabled by therapists' engaged and "not classically psychoanalytic" approach with their patients, which allowed for "real" and genuine contact.

Patients' sense of safety within the relationship laid the groundwork for an effective psychoanalytic intervention. Without it, patients' resistance and limitations to the therapeutic contact increased, as well as their difficulties with working dynamically, as therapists suggested that the sense of threat limited their ability to engage in a creative and unguarded manner with the dynamic exploration. Another challenge to forming an effective intervention was therapists' sense of "colluding" with their patients' pathology. All of these factors, as well as the therapy's infrequent structure, resulted in therapists' significant difficulties with formulating their patients and identifying the effective components in their treatment, which hindered their ability to facilitate an effective psychoanalytic intervention.

An effective psychoanalytic intervention was mostly linked to therapists' ability to identify and address patients' pathologies in a multitude of ways. This resulted in three types of changes: (a) insight gain; (b) internalisation of reflective capacity; and, (c) change in mental structures. All of these changes informed and

enhanced patients' experience of the therapeutic relationship and of the therapist as safe, understanding, and helpful. These changes were also applied by the patients to their external experiences, as patients' used their newly acquired reflective capacity to develop further insight. In addition, patients also relied on their modified structural changes and insight about their internal processes to better function outside of therapy and achieve tangible goals that cemented their progress.

### **3.4 The Relationship Between the Themes and Patients' Long-Term Outcome**

The chi-square tests conducted for all of the themes found only one theme to be associated with patients' long-term remission. This theme was "insight gain" and its relationship was found to be statistically significant  $\chi^2 (1, N = 23) = 4.1, p = 0.043$ , as therapists identified "insight gain" as a helpful factor more among patients whose remission was not sustained. Only one other theme, "therapists' assertive, engaged and not 'classically psychoanalytic' approach", was found to be near significant  $\chi^2 (1, N = 23) = 3.16, p = 0.076$ . This approach was most often identified among patients whose remission was not sustained.

## **4. Discussion**

The aim of this study was to explore therapists' private theories of helpful and challenging factors to the therapeutic process and its outcome in long-term psychoanalytic therapy for TRD. Thematic analysis was used to analyse therapists' accounts and identified a variety of themes regarding the above mentioned helpful and challenging factors. These are discussed in relation to the two main helpful themes that were identified: the formation of the therapeutic relationship as containing and meaningful and the provision of an effective psychoanalytic intervention. These themes will be discussed in succession, followed by a discussion of the challenges that

therapists encountered in the therapy and the factors that helped them to manage these challenges.

#### **4.1 Forming a Containing and Meaningful Therapeutic Relationship**

The analysis found that the formation of a containing and meaningful therapeutic relationship was considered as crucial by most of the therapists in this study, as it formed the necessary foundations to provide an effective intervention. The subtheme that was identified in most of the cases as contributing to the formation of this relationship was patients' experience of it as safe, caring, and understanding. The analysis found that for the most part this was achieved by therapists' adherence to what they considered to be the fundamental components of the therapeutic position, which included carefully listening to their patients, holding them in mind and refraining from attacking them (i.e., demonstrating a non-judgemental and tolerant stance towards them).

These themes were similarly reported in other qualitative studies of therapists' views. For example, Lilliengren and Werbat (2010) found that "developing a close, safe, and trusting relationship" was a core curative theme in their study of psychoanalysts' views of successful treatments. Similarly, this was reportedly achieved by demonstrating genuine interest in the patients and by adapting to their needs. In another study, Levitt and Williams (2010) explored views of therapists from different modalities and also reported that establishing the safety of the relationship was seen as priority by the therapists. In both of these studies, therapists' observations suggested that patients would experience difficulties committing to the "risk taking" required for therapeutic change without this sense of trust and safety being firmly established first.

The analysis in the present study found that therapists fostered patients' sense of care, trust, and safety by "containing" their patients. This construct was originated by Bion (1962), who suggested that in therapy patients project their disturbing and difficult to tolerate mental states. The role of the therapy, and specifically of the therapist in this regard, is to contain these unbearable states, process them, and re-present them to the patients, who can then reintegrate them in a more adaptive manner.

To do so, both the therapy and the therapists must first demonstrate their ability to survive patients' projections (Cartwright, 2014). Therapists' accounts in this study aligned with this theory as they also highlighted the resilience of the therapeutic relationship as a subtheme contributing and enhancing its formation. They suggested that its resilience was demonstrated over time, as the therapy gradually explored patients' disturbances, without the relationship collapsing or becoming hostile in patients' experience.

Another subtheme, which was found to contribute to the formation of the therapeutic relationship as containing and meaningful, was patients' experience of emotional contact with their therapists. This was referred to as moments in which both the patients and their therapists experienced an emotional response to one another, which was subsequently acknowledged in therapy. This resulted in patients' experience of relief and positive emotions, and was often followed by increased engagement with the therapy. These moments have been referred to as moments of "real" contact by several of the therapists in this study. This conceptualisation has been discussed extensively in the literature over the past century, as summarised by Couch (1999). Moments of "real" contact have been defined as moments of realistic and genuine contact between patients and their therapists, which exist outside of the transference (Gelso, 2009). They are considered valuable as they allow patients to

momentarily exit their pathology, reflect on its distortions, and benefit from the nourishing contact with their therapists (Duquette, 2010; Eissler, 1953; Zetzel, 1956). A study by Gelso (2009) provided empirical evidence for this theory, as he reported a positive association between the experience of “real” contact and therapeutic outcome.

The analysis found that once patients’ experienced the relationship as containing and meaningful, their therapists could then focus the therapeutic efforts on addressing patients’ pathology more directly. An explanation for why this pattern was needed was not identified in therapists’ accounts, however, one can be hypothesised based on the literature related to the subthemes discussed earlier. According to psychoanalytic literature, both the containment of patients and moments of “real” emotional contact serve a similar function of strengthening the patients’ egos (Couch, 1999; Steiner, 1996). This provides patients with the capacity to endure and engage with the psychoanalytic exploration, without being overwhelmed by difficult emotions (such as anxiety, guilt and shame) which are associated with the content of their pathology. In the absence of the above mentioned capacity, patients are expected to resist the provision of an effective psychoanalytic intervention, as suggested by Slochower (1992) and as was also identified in the present study.

#### **4.2 Providing an Effective Psychoanalytic Intervention**

The second main theme that was identified as helpful to the therapy was the inclusion of an effective psychoanalytic intervention. Therapists’ accounts suggested that an effective psychoanalytic intervention related to three types of changes induced by the therapy: (a) patients’ gain of insight; (b) patients’ gain of a reflective capacity; and, (c) changes in patients’ internal structures.

Gain of insight is considered one of the most researched areas in psychoanalytic and psychodynamic literature (Blum, 1979; Høglend, 1994; Joahnsson

et al., 2010). Perhaps accordingly, it was also the most frequently identified change by the therapists in the present study. Patients gained insight regarding their own internal world and its effects on their interactions with others. A variety of areas were explored including, for example, patients' difficulties with loss, covert aggression, and difficulties with separation. This offers support for Bleichmar's (2010, 2013) view of TRD of as a broad construct consisting of multiple pathways of depression.

Little systemic empirical study has been conducted regarding patients' gain of insight in psychoanalytic therapies, as only one study investigated it directly and found it (as rated by therapists) to be a predictor of improvement in patients' interpersonal functioning (Johansson et al., 2010). In the present study, insight gain was the only theme that was found to vary significantly between the patients whose remission was sustained by the end of the follow-up period and those for whom it was not. However, contrary to Johansson et al.'s (2010) study, the present study found that therapists identified insight gain more often among patients whose remission was not sustained.

In this regard, it is also interesting to discuss Werbart et al.'s (2018) study of therapists' views of unsuccessful therapies, as the therapists in that study also identified that their patients gained insight. Werbart et al.'s (2018) study and the present study both measured outcome as change in symptoms. As such, it is possible that insight gain is associated with long-term changes in interpersonal functioning, however, not with changes in symptoms. In addition, it is also possible that insight gain might not be associated with patients with TRD long-term remission, as patients might use their insight about their pathological mechanisms to enhance their attacks on self. Such dynamics were reported in the therapies in the present study, as therapists described how their helpful interpretations were at times internalised and realigned with patients' critical and harsh internal objects, to be then used as self-attacks. Thus,



it is possible that the gain of insight is not enough to sustain patients' remission, and that further changes are required (such as the one described below) to ensure that patients use their insight in an adaptive manner rather than in a manner which reinforces their pathology.

The analysis found that therapists made a distinction between patients' gain of insight and their gain of a reflective and analytical capacity. As opposed to gain of insight, this capacity was not identified differently depending on patients' long-term sustainment of remission. This capacity has been referred to in psychoanalytic literature as self-analytical. It has been considered one of the main aims of psychoanalytic therapy (including by the manual guiding the TADS' intervention) as patients' remission has been linked to their internalisation of their therapists' analytical capacity (Freud, 1937; Hoffer, 1950; Horney, 1942; Taylor, 2015). This has also been supported in a study by Falkenström, Grant, Broberg and Sandell (2007) which analysed patients' accounts and found that in both psychoanalytic and psychodynamic therapies, patients' gain of self-analytical capacity was associated with good long-term outcome. The present study supported this finding from therapists' perspectives.

The analysis also found that patients who acquired this capacity were also reported to make use of it and apply it to external circumstances outside their sessions, which was identified as a helpful factor. This has been suggested in psychoanalytic literature to be an important component in the process of patients' internalisation of self-analytical capacity, as patients are suggested to first test this capacity and its benefits before solidly adopting it (Ticho, 1967).

The third type of change that was found in the analysis, and was the least common of the three, was changes in the patients' internal structures and representations of internal objects. Therapists' accounts suggested that this was

achieved in two manners. The first, was achieved via patients' internalisation of their therapists as good objects. This has long been considered one the main aims of psychoanalytic therapy (Klein, 1950), as the internalisation of a good object "serves as a focal point for the establishment of healthier object-relations" (Loewald, 1960, p. 32) both within patients' internal world and for use in their relationships with others. The second, was achieved by reducing the potency of patients' harsh internal objects and realigning the patients with good objects, which were either internalised, recovered or enriched during the therapy.

Therapists' views regarding this dynamic of change align with the theory and empirical research conducted by Blatt (1992, 1995, 1998, 2004) as part of his investigation of the introjective subtype of depression. He suggested that patients who experience this subtype of depression are characterised by having harsh and judgemental internal objects. Thus, the aim of the therapy is to revise the internal representations of these objects, which according to Blatt's research proved effective in the treatment of these patients. Thus, it would be interesting for future research to explore whether this subtheme is more prevalent in the cases of patients with the introjective subtype of depression than other patients.

The second subtheme that was found in the analysis to contribute to an effective psychoanalytic intervention, was therapists' use of multiple techniques to address the various pathological mechanisms identified. Therapists' accounts suggested that they did not consider TRD as consisting of a single formulation, with several of therapists explicitly stating how their views of the condition changed and expanded throughout the therapy. Accordingly, therapists' use of psychoanalytic techniques was tailored to their formulations of their patients' pathological mechanisms.

This finding aligns with Bleichmar's (2010, 2013) theory, which suggests that TRD is a category containing many different forms of depression, each with its own unique pathway, which eventually lead to a shared symptomology. As such, Bleichmar highlighted the importance of therapists' flexibility and broad thinking when formulating their patients' pathological mechanism and when deciding upon the appropriate techniques to address them. The analysis suggested that more than half of the therapists essentially followed Bleichmar's thesis.

#### **4.3 The Challenges to The Therapeutic Process and Its Outcome**

The analysis found that the therapists experienced the therapies in the present study as fraught with challenges throughout their course. These challenges interfered with the two main helpful themes discussed above: the formation and sustainment of the therapeutic relationship as containing and meaningful and the provision of an effective psychoanalytic intervention. The challenges were most often attributed by the therapists to the effects of patients' pathology, as this was identified in six of the subthemes (in comparison, therapists attributed these challenges to their approach in only a minority of the cases and in none of the cases suggested that they lacked the skills or knowledge to treat these patients effectively).

The analysis found that the most common challenging subtheme was patients' experience of the therapeutic relationship as threatening, unsafe, and careless, which in several of the cases was exacerbated by patients' experience of the therapeutic relationship as hopeless and futile. Both of these subthemes were suggested to be the result of the patients' pathological mechanisms, which undermined, nullified or "toxified" any positive representations of the therapy, and especially of their therapists, who were often viewed as dangerous objects. This, resulted in patients' heightened sense of anxiety and defensiveness, which patients managed by limiting their

engagement and contact with their therapists, which greatly interfered with therapists' efforts to establish the therapeutic relationship in a positive manner.

These challenges persisted even after patients began to experience the therapeutic relationship as safe and caring. Therapists attempted to explore and address patients' pathologies, which in turn elicited difficult emotions for their patients. As discussed earlier, patients managed these emotions by limiting contact, although in this context, with their internal disturbances, rather than their therapists. This curtailed the dynamic exploration and the employment of psychoanalytic techniques, which interfered with therapists' efforts to provide an effective psychoanalytic intervention. This left the therapists feeling hopeless regarding the possibility of understanding their patients and/or generating change. Several of the therapists suggested that as a result they found themselves "colluding" or "succumbing" to their patients' pathologies, which resulted in futile repetition and re-enactment of patients' pathologies in session.

These persistent challenges can perhaps explain the difference between the findings of the present and Werbart, Missios, Waldenström and Lilliengren's (2017) study, which also systematically explored therapists' views of successful psychoanalytic therapies, however, for patients with general psychological difficulties. That study reported that successful therapies were characterised by the therapists experiencing a "positively charged therapeutic relationship", which included positive feelings towards the patients and a sense of collaboration. In comparison, these themes were almost entirely absent in therapists' accounts in the present study, as therapists' positive feelings towards their patients were found in only three of the cases. Notably, the themes that were identified in the present study were more similar to the themes identified in Werbart, Below, Engqvist and Lind's (2018) study, which was based on the same data as Werbart et al.'s (2017) study, however, explored therapists' accounts

of the unsuccessful therapies. Similar to the findings in the present study, Werbart et al.'s (2018) study also found that these therapies' were characterised by distance in the therapeutic relationship, therapists' sense of lack of control over the therapy, and an overall sense of futility.

In addition, the themes identified in the present study were also reported in individual accounts of expert psychoanalysts in their work with patients with TRD. For example, Jacobson (1954), reported a sense of tenuousness when working with these patients, as any contact made could have easily been "absorbed" by their pathology, which would prevent them from "associating freely or digesting any interpretation" (p. 603); Sullivan (1954) highlighted the difficulties of understanding these patients as they remain highly obscure throughout the therapeutic process; Bonime (1982) suggested therapists' experience of "frustration, impotence, failure, resentment" in response to these patients to be a feature of these therapies; more recently, Leuzinger-Bohleber (2015) reported that as part of her work in the aforementioned LAC study she treated a patient who had a significant "lack of a sense of basic trust in a helping object" (p. 630), which impacted the treatment and was linked to an experience of early trauma. She suggested this issue to be a common feature in therapies for patients with TRD, as the majority of the patients in the LAC study were found to have experienced severely traumatising events (estimations ranging between 76% and 84% depending on the patient or the therapist rating).

Considering the above, it appears that the challenges identified by the therapists in the present study are a prominent feature of therapies involving patients with TRD, as these challenges are inherent and a direct result of their pathology. This might also explain why this group of patients do not often respond to therapeutic

interventions, as these challenges undermine therapists' efforts to form a therapeutic relationship and provide an effective intervention.

#### **4.4 Helpful Factors to Managing the Therapeutic Challenges**

As discussed above, many challenges affected the therapies in the present study. However, they did not prevent therapeutic changes from eventually taking place, as evident in patients' experience of remission post-treatment. Thus, it is of value to discuss how these challenges were managed by the therapists in this study.

The analysis suggested that therapists managed these challenges by focusing their therapeutic efforts on promoting patients' positive view of the therapy, which is also known as patients' "positive transference" (Freud, 1912; Klein, 1950). The analysis suggested that this was mostly achieved by the therapists' effective containment of their patients over a period of time, and that it was the quality and the consistency of this effort which eventually paved the way for patients' positive experience of the therapeutic relationship. This is in line with Slochower's (1992) theory relating to therapy with highly disturbed patients, which suggests that these patients require a slow and gradual build-up of their trust and "confidence in a reliable analytic environment" (Slochower, 1992, p.74).

However, the analysis also found that the therapists experienced difficulties in effectively containing their patients, as they were at times affected and overwhelmed by their patients' pathology. Therapists' accounts suggested that the use of peer-supervision was helpful in this regard, as it provided therapists with support as well as highlighted their difficulties with containing and holding their patients in mind. The importance of supervision in the work with patients with TRD has also been discussed by Plakun (2003), Steiner (1996) and Leuzinger-Bohleber (2015). They highlighted the difficulties in containing these patients due to their powerful and disturbing

projections within the transference, which can result in therapists joining patients' enactments and/or defences against their internal "terror", rather than addressing them therapeutically. These authors highlighted the importance of supervision in this regard as it can identify therapists' defensive needs that resulted in their deviation from the therapeutic stance.

In this regard, it is interesting to discuss the near-significant finding, which found that theme of therapists' "assertive, engaged and not 'classically psychoanalytic' approach" was more frequently identified among patients whose remission was not sustained. While therapists' accounts suggested that the above mentioned approach was helpful to the therapies, its greater presence in the less successful cases perhaps suggests that their deviation from the psychoanalytic approach was the result of the effects of patients' pathology, rather than a conscious clinical decision.

Another subtheme that was found to be helpful in mitigating the therapeutic challenges, regarded the contribution of external factors, namely personnel involved in the patients' care (such as patients' GPs, admin staff and research team personnel). These factors provided patients with additional containment, which reduced their anxieties in the therapy. In several of the cases, these factors also provided explicit support by advocating the potential benefits of psychoanalytic therapy, which contributed to the formation of the positive transference. Therapists' views on this matter align with Krikorian and Fowler's (2008) theory regarding the importance of a team approach in the treatment of patients with TRD. Krikorian and Fowler suggest that the involvement of external personnel functions as an additional "container" for these patients. This, as it allows the patients to further process the "projections and unmanageable affects" (Krikorian & Fowler, 2008, p. 356) that are elicited as result of their engagement with the therapy.

## **4.5 Limitations**

This study has several limitations. First, all of the stages in the thematic analysis, with the exception of the final stage, were completed solely by the author of this study. This poses a threat to the reliability of the data, as researcher triangulation is considered a valuable means of establishing it and limiting bias (Morrow, 2005). Researcher triangulation was not possible in this study due to limitations on time, availability, and confidentiality.

Second, the study's setting limits the ability to generalise the findings. It was conducted in the specific context of the Tavistock clinic and was thus informed by a specific theoretical framework, detailed briefly at the beginning of this paper. In addition, it was also conducted in the context of a large study, which patients were aware of and responded to. Both of these setting-related variables were identified as factors which affected the patients' therapies. This raises the question of whether these findings can be generalised to individual long-term psychoanalytic therapies which do not take place within a large service and/or study.

Third, the inclusion criteria for this study was based solely on the HDRS as its outcome measure, as such, outcome was only assessed as change in symptoms and not in other areas, such as interpersonal distress and functioning. Outcome was defined as partial remission based on an HDRS cut-off score. This approach has been criticised as it has not been empirically validated (Zimmerman, Posternak & Chelminski, 2005). In addition, the outcome was measured at discrete time points during the follow-up rather than as part of a longitudinal trajectory. Thus, it is possible that the reduction in symptoms was the result of the cyclical nature of depression rather than therapeutic change.



Fourth, the analysis was unable to discern between the factors relevant to the therapeutic process and factors relevant to its outcome. This distinction appears to be meaningful, as during the interviews therapists suggested that some factors were helpful to the therapeutic process (e.g., facilitating dynamic exploration), however, did not necessarily result in a change in outcome (e.g., therapists reported that for many patients any therapeutic gains were eventually ‘annihilated’ by their pathological mechanisms, thus resulting in no change in outcome, despite a positive process of productive psychoanalytic exploration). Thus, there appears to be value in investigating these areas separately, as their factors do not necessarily overlap. However, this ambiguity predominated most interviews, possibly due to the open nature of the PTI. As such, the present study did not make a distinction between these areas, and all factors identified are considered as relevant to the therapeutic process and/or its outcome.

Fifth, the exploratory statistical analysis which was conducted in the study had small power due to the limited number of cases. However, it should be stated that it still met the statistical assumptions required by the chi-square tests.

#### **4.6 Recommendations for Clinical Practice**

The findings in the present study touch upon the complexity of working with patients with TRD. It suggests that therapeutic efforts should be heavily directed towards establishing the therapeutic relationship as safe, containing, and meaningful. As such, therapists are required to effectively contain and hold their patients over an extended period of time by developing a well-rounded and resilient relationship. This, before using more direct psychoanalytic techniques to address their pathologies, as attempts to do so prior to patients’ experience of safety are expected to be met with suspicion, anxiety, limitation of contact, and rejection of the therapeutic efforts.

In line with the literature regarding therapists' experience of working with patients with TRD (Leuzinger-Bohleber, 2015; Plakun, 2003; Steiner, 1996), the therapists in the present study highlighted the challenges of effectively containing these patients. This, mostly due to the severity of their projections, which greatly affected the therapists. As such, the treatment of patients with TRD would benefit from: (a) provision of supervision for the therapists to better manage their countertransference; and, (b) mobilising external factors involved in the patients care to provide them with active encouragement for their continued engagement with the therapy, in addition to further containment outside of the sessions.

The findings of the present study suggest that there is no single pathway for depression nor is there a single technique for its treatment, as has also been suggested by Bleichmar (2010, 2013). Rather, it appears that effectiveness of the psychoanalytic intervention depends on the therapists' ability to identify the pathology and use appropriate means to address it. While doing so, therapists would benefit from adapting a continuously reflective stance which holds their patients in mind and reflects on the way in which the therapists and their actions are perceived. This is highly important as patients with TRD can often undermine and "toxify" the internalised representation of their therapists and their efforts, resulting in a need to return and address the therapeutic relationship.

The present study also raises questions as to the long-term effectiveness of insight. While this requires further research, the findings suggest that patients are more likely to benefit more from the internalisation of a thoughtful reflective capacity and changes in their internal structures. In addition, encouraging patients to apply this capacity to external events outside of therapy also appeared to be valuable, as this

enhanced the therapy by providing further material for reflection, tangible goals and achievements for the patients.

#### **4.7 Recommendations for Future Research**

Considering the above limitations, it is apparent that future research investigating therapists' views of helpful and challenging factors in psychoanalytic therapy for treatment of TRD, would benefit from the following:

First, as TRD consists of several types of depression, each with their own unique mechanisms and appropriate interventions, future research would benefit from a greater number of patients for its systemic analysis. In addition, integrating patients' characteristics into the analysis would provide more detailed findings regarding the helpful and challenging factors for treatment. This study's findings regarding therapists' identified changes in patients' introjects are especially intriguing in this regard, as it would be interesting to explore whether they are identified more often among patients experiencing introjective depression.

Second, the study found that despite patients' experience of the relationship as dangerous and threatening, they experienced moments of safeness within it, which were crucial for the therapeutic work. The therapists in the study suggested that this was established over a period time, however, they were unable to identify the mechanisms and the turning points that led to these changes. It would be helpful to develop a better understanding of the factors and mechanisms that eventually facilitated patients' trust or positive transference to their therapist, as this appeared to be the main challenge in working with this group of patients. It would be particularly interesting to explore this in the context of epistemic trust, due to its implied centrality in the accounts of therapists working with patients with TRD.

Third, identifying the factors that are relevant to the therapeutic process and identifying the factors that are relevant to long-term stable remission appear to be two distinct research questions. As such, interviews exploring these factors would benefit from an approach which differentiates between the two types of factors and explores them separately with the therapists. Research would benefit from clarifying during data collection, what in the therapists' views constitutes a successful outcome, and/or alternatively, explore this in the context of the outcome as it is measured in the study (for example what factors are associated with long-term stable reduction in symptoms).

Fourth, the study of long-term outcome would benefit from more encompassing measurements of symptom over time. This, for example, by: inclusion of additional measurements of other factors that might influence long-term outcome, such as a negative life events interview (Huber et al., 2017); use of longitudinal outcome measures (such as the longitudinal interval follow-up evaluation measures (Keller et al., 1987)); and, inclusion of repeated measurement of outcome to allow a trajectory analysis rather than one based on discrete points in time.

Fifth, the study found that therapists identified insight gain more often among patients whose remission was not sustained in the long-term. Thus, it would be helpful to expand the research on the relationship between insight and outcome, and specifically outcome as measured by change in symptoms.

Sixth, with regards to the research of helpful and challenging factors in general, the study of therapists' views represents only one point of view, with the other being patients' views. Combining these perspectives could provide valuable insight, as evident in the studies conducted by Werbart et al. (2017, 2018).

Seven, the themes drawn from therapists' views regarding their experience of the therapeutic process can easily be reformulated and discussed in other psychological theoretical frameworks, beyond the psychoanalytic framework chosen for this paper. This appears to be especially viable in the context of this study, as many of the therapists reported difficulties in administering "classical" psychoanalytic techniques during extensive parts of the therapies. Instead, they highlighted the need to invest great amounts of time and effort in first establishing the patients' sense of the therapy as a safe environment for psychological learning and exploration. As mentioned earlier in the discussion, Levitt and Williams (2010) suggested that this view is shared by all therapists regardless of their therapeutic approaches. As such, discussing this within a generic framework, such as the one offered by the theory of epistemic trust (Fonagy & Campbell, 2017), would perhaps be more suitable in describing a process that is considered as pertinent to all therapies regardless of model.

According to the theory of epistemic trust the core of the challenges of patients with severe difficulties (such as the patients in this study) stems from a breakdown in their epistemic trust, which limits their capacity to engage in the process of psychological learning that enable them to adjust maladaptive mental structures (whether they are conceptualised as cognitions in a CBT framework or as object relations in a psychoanalytic framework) (Fonagy & Campbell, 2017). As such, the theory suggests that therapeutic efforts should first be made to reinstate patients' epistemic trust, as in its absence the therapeutic effort can be "rejected, its meaning confused, or [...] misinterpreted as having hostile intent" (Fonagy & Campbell, 2017, p. 284), as was often reported in the therapies in this study.

The theory of epistemic trust has provided the basis for Mentalization Based Therapy (MBT) (Fonagy & Bateman, 2006), which suggests that epistemic trust can

be therapeutically recovered by repeated acts of mentalization in therapy. However, it can also be argued that epistemic trust can be restored in other pathways depending on the therapeutic approach. For example, by conducting experiments as part of CBT's collaborative empiricism approach or by containment and insight as suggested by the psychoanalysts in this study. Due to the limitations of this paper it is not possible to delve deeper into such alternative formulations, however, these examples demonstrate the flexibility of the results of the thematic analysis of this study and its potential to facilitate a wider therapeutic discourse. As such, it appears that future research would benefit from discussing the findings of this study in other frameworks in greater detail, as it would allow therapists to learn from the experience of therapists from other orientations (with whom they often have little shared discourse), who were also able to achieve a good outcome despite differences in approach.

#### **4.8 Conclusions**

The analysis of therapists' accounts found that psychoanalytic therapy of patients with TRD benefited from a focus on the formation of the therapeutic relationship as containing and meaningful for these patients. Once this was established, therapists could then address patients' pathology in a more direct manner. The analysis highlighted the importance of identifying patients' pathological mechanisms, which are mostly unique to each patient, and the importance of administering the appropriate techniques accordingly. These factors contributed to an effective psychoanalytic intervention, which consisted of the following changes: insight gain, changes in the patients' internal structures, and internalisation of a reflective capacity. Many challenges were identified in the therapeutic process while working with this group of patients, mostly due to the nature of their pathology. These were found to be mitigated by therapists' focus on effective and consistent containment of patients, their use of

peer supervision, and the contribution of external factors to patients' sense of containment and positive transference in the therapy. Further research is needed to develop a more systemic understanding of the different subtypes of depression which constitute TRD and a more refined understanding of the therapeutic mechanisms which promote patients' sense of trust and safety within the therapy. In addition, further research is required with regards to the role of insight in long-term outcome, as this was the only theme that was identified as significantly different between patients for whom remission was sustained and those for whom it was not.

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### **Part 3: Critical Appraisal**

## **Introduction**

This critical appraisal discusses several issues that I found intriguing and potentially valuable for future research. It offers my reflections on issues regarding conducting research in the psychoanalytic field, suggests an alternative perspective of the findings, and finally discusses the manner in which therapists' work with TRD potentially affected their engagement with the research.

### **Reflections on Conducting Research in the Psychoanalytic Field**

As demonstrated in the literature review conducted as part of this thesis, the state of the empirical research of psychoanalysis and psychoanalytic therapies is disconcerting (this is also true, although to a lesser extent with regards, to the research of long-term psychodynamic therapies). This has been discussed over the past two decades in great detail and with great urgency, due to the rise of evidence-based practice and the focus on cost-effective interventions provided as part of public-managed care, which faces increasingly limited resources (Leuzinger-Bohleber, 2015). Psychoanalysis and psychoanalytic therapies have been considered at a disadvantage in this regard, due to their historical lack of evidence and associated high costs, for which they have been criticised at great length (Fonagy, Lemma, Salkovskis, & Wolpert, 2012). This lack of evidence has been attributed to various factors, two of which will be discussed regarding their effects on the research process as part of my reflection.

### **Reflections on the Effects of Therapists' Attitudes Towards Research**

One of the factors that has been suggested as contributing to the lack of evidence, relates to therapists' approaches and attitudes towards empirical systematic research within the psychoanalytic field. These attitudes have been considered to be not widely supportive, perhaps due to the ongoing internal debate within the field

regarding this type of research, which has persisted since the origins of psychoanalysis (Fonagy, 2000; Wallerstein, 2000). This, as therapists and scholars have been questioning the possibility and purpose of systematic research of these therapies, suggesting that advances in the field are derived, not from this type of research, but from the theory and practice developments conceived in the mind of individuals (Kernberg, 2006; Spence, 1994). Others have expressed a more critical position, warning against the negative effects of research on clinical practice and suggesting that such research would result in a reductionist approach that poses a danger to the integrity of psychoanalysis (Green, 2000). Thus, some within the field resist the application of formal and systematic research methods, and instead suggest that the single case methods are the only valid manner of investigating these therapies, as only they can capture the complexity of psychoanalytic theory and of the human psyche.

Before starting this research project, I was not fully aware of the resistance that exists within the field towards empirical systematic research. I became more aware of this when I conducted the literature review and found an unexpectedly small number of relevant studies. In addition, this issue became more prominent when I began listening to the interviews, which were used for the analysis in my empirical paper. As I was listening to them, I began to notice that a few of the therapists were reluctant to engage in the interviews and/or sounded adverse and defensive. It should be noted that this was a relatively minor subgroup of the therapists, as most therapists in the study were very cooperative. However, therapists' attitudes within this subgroup were very prominent and intriguing.

In addition, the more contact I had with other researchers in the field throughout the work, the more that I heard about similar experiences. They shared that some therapists engaged in a very limited manner with the research efforts and these

therapists often expressed their concerns about the effects of the research on their therapies. In the context of my study, I noticed it in several of the interviews, in which therapists expressed concerns regarding the impact of the research on therapy and its interference with the therapeutic dyad and the transference. In one specific interview, concerns were voiced by the therapist regarding the recording of the therapies and the manner in which it enhanced patients' sense of feeling unsafe in the therapy (which was identified as one of the main challenges in the empirical paper). The therapist reported it as follows:

“I think she experienced being in this research study, a bit like... especially with this tape. There was a sense of this unseen audience who were watching her, and in her mind would be listening to her and mocking her. So again a sense of something quite excruciating about the therapy as a kind of experience, as a kind of repetition of something. Was this just some exercise where she was going to be exposed and humiliated, and laughed at?”

Other therapists in the study also expressed their discontent with the research due to its pre-set design which they felt negatively affected the therapies they provided. This was identified in the analysis in the empirical paper as one of the more prevalent themes that therapists felt led to challenges in the therapy. Specifically, therapists suggested that therapies' length being known to the patients affected their sense of safety due to their sensitivity to loss and rejection. In addition, they also suggested that the temporal periods offered for the therapies was incompatible with patients' difficulties, which required a considerable amount of time. Some therapists reported their frustration with having to finish the therapy after set period of time, as one therapist stated: “And I want to say, really, that if she was my private patient, I wouldn't dream of ending at that point”. It is possible that therapists in this study

responded to the restrictions of TADS design in this manner, as most of them were not accustomed to working within a timeframe defined in advance. In addition, they were not accustomed to providing, what they did not consider to be long-term therapies. Many of them suggested that without the study restrictions, they would have probably seen some of these patients for years.

On reflection, it is possible that therapists' unfavourable views of the research informed in their engagement with the interviews. As such, it would be interesting for future research to systematically investigate the manner in which therapists' position towards research affected their engagement with it. It would be especially interesting to contrast in this regard, between therapists' accounts provided during peer-supervision and between the accounts provided in research interviews, as they cover similar areas. In addition, it would appear that research in the psychoanalytic field would benefit from facilitating better communication between therapists and researchers. This, as therapists' concerns and researchers aims could be jointly discussed in a manner that could perhaps alleviate therapists' aversion to research and result in better research planning to mitigate some of the research effects on treatment.

In addition, it is not clear if therapists' unfavourable views of research are rooted in empirical evidence, and thus studies on the impact of research could contribute to addressing this mismatch. In this regard, it is of interest to discuss the findings of the empirical paper, which found that several of therapists reported that the involvement of the research team was eventually helpful for the therapeutic process and its outcome. This, as they suggested that the research staff provided further containment and a sense unconditional interest in the patients. The staff were also found to be supportive of the patients and encouraged their participation in the therapy, which in several of cases was suggested to be very helpful, as it helped form patients'

positive transference. It should be stated that these findings were attained in the investigation of the successful cases, and thus there is a need to explore these aspects in the whole sample, as research effects were perhaps more prominent in the less successful cases. Once this is done, it is my belief that communicating these findings to the therapists might prove helpful in facilitating greater engagement with future research.

### **Reflections on the Effects of the Pluralism of Psychoanalytic Theories on Research**

Another factor that has been suggested as contributing to the lack of evidence within the psychoanalytic field is the multiplicity of theories that exist. This has been referred to as “extreme pluralism” as it results in a fragmented discussion between different schools of thought within the field (Fonagy, 2000; Grünbaum, 2001). Perhaps the best example of this has been provided in Hamilton’s (1996) work, which systematically explored therapists’ views on the most fundamental and common psychoanalytic theoretical constructs, such as transference, and found that that therapists had significantly diverging and incompatible views, based on their orientation. As demonstrated in the literature review in the thesis, this problem is also relevant to the research into psychoanalytic therapies, as research explored a wide variety of theoretical constructs, which hinders the ability to synthesise findings into a shared and coherent knowledgebase. In addition, very little research has been done in an attempt to explore the effectiveness of psychoanalytic therapies based on the theoretical knowledge that informs them, as often they are grouped into a single category of psychoanalysis or psychoanalytic therapy based on extrinsic criteria. As such, all of these theories exist side by side with very little empirical reason to favour one over the other.

On reflection, I found this aspect quite challenging during my research and it shaped my decisions with regards to two components of the empirical paper: the qualitative analysis method and the discussion.

With regards to the qualitative analysis, I believe that the theoretical pluralism within the field means that research would benefit more from a qualitative approach “essentially independent of theory and epistemology”, such as thematic analysis (Braun & Clarke, 2006, p. 82). In addition, it appeared that theoretical pluralism also exists between the different therapists interviewed for this study. Thus, I saw great value in an approach that would attempt to find recurring patterns within the data, as it would focus on the shared factors described by the therapists, which I aimed to identify. As such, other qualitative approaches such as narrative or language-based approaches appeared less appropriate, as both could replicate the pluralism, rather than mitigate it. In addition, within the thematic analysis category, I believe that the approach I used, often referred to as “generic analysis” (Pistrang & Barker, 2012), is most suitable to address the difficulty I identified. Other approaches such as grounded analysis were considered, however, they seemed less appropriate due to, first of all, the high number of interviews analysed in the study (Mcleod, 2012), and second, their aim of generating a theory, while valuable, appeared to be counterproductive. Instead, I believed that thematic analysis would generate a list of themes, which may then invite different readings from different theoretical perspectives, and thus be more beneficial overall.

With regards to the discussions, a certain theoretical approach was needed in this part of the study to discuss the findings and anchor them in the wider literature. As such, I decided to discuss these findings based on the theoretical terms most often used by the therapists in this study, and based on the leading theorists which were



identified in the TADS manual as influencing the work in the Tavistock clinic. I believe that this was important to maintain a coherent discussion in the findings, which would still reflect the main theories underpinning the therapists' private theories. This, while still referring to additional scholars which were not mentioned by interviews, to fill what I perceived as theoretical lacunas in therapists' accounts. However, it should be noted that despite my efforts to follow therapists' theories, the discussion is of course still very much influenced by my propensity to different theories which resonate with me. Thus, it is possible that a different approach which discusses these findings in a completely different theoretical framework is perhaps also of value. An example of such is discussed below.

### **An Alternative Discussion of the Findings**

As stated, I believe that the themes identified offer different readings from different theoretical perspectives. In my discussion in the empirical paper I tried to adhere to what I perceived as the therapists' theories which were mostly based on British object-relations conceptualisation. However, the findings also resonated in my mind with a different framework which focuses on epistemic trust (Fonagy & Campbell, 2017). This was the case, as the main challenges identified in this study could be easily conceptualised as stemming from patients' breakdown of epistemic trust, which has been suggested to characterise patients with TRD thought never empirically explored (Fonagy & Campbell, 2017). Therapists' accounts in this regard were very similar to Fonagy and Campbell's (2017) report of the challenges of working with patients with high levels of epistemic mistrust. In this study, the authors describe patients' hypervigilance and rigidity, which result in the therapeutic effort being "rejected, its meaning confused, or [...] misinterpreted as having hostile intent" (Fonagy & Campbell, 2017, p. 284), as often happened in the therapies in this study.

This framework also highlights the challenges in working with these patients, and specifically the risk of therapists losing their capacity to mentalise their patients, which was one of the challenging themes found in the empirical paper (Bateman & Fonagy, 2010).

Using this framework also provides a different conceptualisation of the helpful factors identified. For example, according to this framework, patients' trust in the relationship is gradually built, not due to containment, but rather due to their therapists' ability to mentalise them. As such, moments which were referred as moments of "real" contact were, according to this framework, moments in which therapists demonstrated their capacity to mentalise the patients, which also provides an explanation for why the acknowledgment of patients' emotions was important during such moments. In addition, this framework also suggests that the most helpful change to these patients is their ability to develop a metalizing capacity, rather than insight, which offers a potential explanation as to why it was not associated with long-term outcome. It also offers a different explanation for the contribution of external factors, as rather than providing further containment, these factors were in fact people with whom patients had epistemic trust, and who, in their actions, were able to extend such trust to the patients' therapists. On reflection, I believe that future research would benefit from exploring these patients within this framework, especially as this framework is much more grounded in systematic research in comparison to a classic psychoanalytic conceptualisation.

### **Reflection on the Effects of TRD on Therapists' Interviews**

The last area that I would like to reflect on is with regards to the effects of work with patients with TRD on their therapists. As found in the empirical paper, several of the therapists reported that they felt that they identified with their patients' projections,

resulting in their experience of a sense of despair about therapy and regarding their own skills. It is possible that therapists were not able to identify these projections, and thus carried a sense of failure regarding these therapies after they were completed. As such, this can also explain therapists' aversion to attending the interviews and their defensiveness expressed during them.

This was perhaps best exemplified in one of the interviews, in which a therapist came to realise this dynamic near the end of the interview: "One thing that's interesting is the extent to which I felt I was being a bad, useless therapist throughout this experience. and I suppose that kind of counter-transference, I think, which is about me taking on something of what she was experiencing - this sense of being useless and really a sense of being a failure. And I didn't- because as you know, I didn't even want to do this interview because I thought 'god, do I have to? [what] kind of bad impression am I going to make'. That is something that is quite powerfully or so projected into me. And then the more I talk about it now, the more I get a sense 'actually- this, you know, this wasn't such a useless therapy after all, maybe it really did help her'."

In this example, the therapist was able to reflect and identify the manner in which she identified with her patients' projection, which in turn affected her account during the interview and her perception of the outcome of the therapy, which is especially interesting, as her patient was found to experience long-term partial remission. Thus, it is possible that in many other cases, therapists were unable to identify this dynamic in a manner which affected their interviews. As such, it would perhaps be beneficial in the future to conduct these interviews in two stages: the first, while the therapist is blind to the outcome of the therapy, and the second in which therapist is aware of the outcome. This could help therapist reconsider their views and

perhaps similar to the quoted therapist, enable them to report their experience in a more complex and in-depth manner, which would enrich the research.

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## **Appendices**

## Appendix A: Characteristics of the Main Research Projects of the Included Studies

Research Project	Treatment(s)	Main difficulties	Sample(s)	Therapists (average years of experience)	Treatment duration (in months)	Number of sessions	Post termination follow-up (in years)	Outcome measures	Outcome measurements	Process measures	Included studies based on this data
MPS (Huber,et al., 2013)	PA, PDT, CBT	Depressive disorder	PA (N = 35), PDT (N = 31), CBT (N = 34)	N = 14 (M = 15)	PA (M= 39.3, SD = 16.6), PDT (M = 32.6, SD = 24.2)	PA (M = 241.3, SD = 89.9), PDT (M = 85.4, SD = 56.5)	3	BDI, SCL-90, IIP-C	Every 6 months in treatment and annually in follow-up	SPC, INTREX, HAQ-T, HAQ-P,	(1) Zimmermann et al. (2015); (2) Klug et al. (2016); (3) Huber et al. (2017)
STOPPP (Sandell et al, 2000)	PA, PDT	General difficulties	PA (N = 74), PDT (N = 331)	N = 209 (M = ?)	PA (M = 54; SD = 23) PDT(M = 46; SD = 24)	PA ((M = 642, SD = 324), PDT (M=233, SD = 151)	3	SCL-90, SAS, SOCS	Annually	TIQ	(1) Sandell et al. (2000); (2) Sandell et al. (2007); (3) Sandell et al. (2006); (4) Falkenström et al. (2007)
YAPP (Philips, et al., 2006)	PA – Individual and Group	Depression, anxiety, OCD, PD	Individual PA (N = 92) Group PA (N = 42)	N = 37 (M = 10.3)	M = 19, SD = 13.8	?	1.5	SCL-90	Pre-treatment, termination and at 1.5 years follow-up	HAQ-II-T, HAQ-II-P	(1) Lindgren et al. (2010); (2) Lilliengren et al. (2015); (3) Werbart at al. (2017)
HPS (Knekt et al., 2008)	PA, PDT	Anxiety and mood disorders	PA (N = 41), PDT (N = 129)	N = 58 (M = ?)	PA (M = 56.3, SD = 21.3), PDT (M=31.3, SD = 11.9)	?	Varied as fixed follow-up of five years was measured from beginning of treatment	GAF, HDRS, HARS, SCL-90, BDI, IIP	Annually for five years	DPCCQ, WAIS, LPO	(1) Heinonen et al. (2014); (2) Knekt et al. (2014);

LTDPRP (Bond & Perry, 2004)	PDT	Depressive, anxiety and/or personality disorder	N = 53	N = 22 (M = 13.1)	M = 36, SD = 25.2	?	Varied as fixed follow- up of five years was measured from beginning of treatment (M = 4.2 months, SD = 2.0 months)	GAF, SCL-90	Every 6 months	DSQ	Bond and Perry (2004)
Werbart & Forsstrom's (2014) unspecified project	PA	Depression, anxiety, anorexia and self-harm	N = 14	N = 8 (M = 8)	M = 61, SD = 14.7	?	2	SCL-90- GSI, SASB, SOC	Pre-treatment, termination and at 2 years follow-up	Change after psychotherapy interview	Werbart & Forsstrom (2014)
NMSPOP (Havik et al., 1995)	PDT	Anxiety, affective, somatization and personality disorders	N = 255	N = 46 (M = 10, SD = 6.57	?	M = 51, SD = 59	2	GAF, SCL-90, IIP-64	Pre-treatment, termination and at 0.5, 1 and 2 years follow-up	DPCCQ, Affect consciousness interview, WAI	(1) Nissen-Lie et al. (2013); (2) Solbakken et al. (2017)

*Note.* PDT = Psychodynamic Therapy; PA = Psychoanalytic Therapy; CBT = Cognitive Behavioural Therapy; BDI = Beck Depression Inventory; IIP = Interpersonal Problems; INTREX = Introject Affiliation; HAQ = Helping Alliance Questionnaire; SPC = Scales of Psychological Capacities; SCL-90 = Symptom CheckList-90; GAF = Global Assessment of Functioning; ORI = Object Relations Interview; DPCCQ = The Development of Psychotherapists Common Core Questionnaire; DSQ = Defense Style Questionnaire; NLP – Negative Life events; TIQ - Therapeutic Identity Questionnaire; LPO = Level of Personality Organization; AC = Affect Consciousness.



## Appendix B: Summary of the review findings

Factors	Interaction with other factors	Reduction in symptoms distress	Reduction in interpersonal distress	Improved functioning	Mediator hypothesis	Theoretical model informing the study
<u>4.1 The therapist</u>						
Therapists reported therapeutic style being supportive	Model of therapy - association only found in PD but not PA (Heinonen et al., 2013; Sandell et al., 2000)	Positive association (Heinonen et al., 2013; Sandell et al., 2000, 2006)			Not supported (Sandell et al., 2006)	
Therapists' views on kindness being a curative factor		Positive association (Sandell et al., 2000, 2006)			Not supported (Sandell et al., 2006)	
Therapists' views on therapy being a form of artistry		Positive association (Sandell et al., 2000, 2006)			Not supported (Sandell et al., 2006)	
Therapists reported professional self-doubt		No association (Nissen-Lie et al., 2013; Sandell et al., 2006, 2007)	Positive association (Nissen-Lie et al., 2013)			
Therapists reported negative personal response to their patient		No association (Nissen-Lie et al., 2013)	Negative association (Nissen-Lie et al., 2013)			
therapists' reported Advanced Relational Skills (ARS)	Moderated by therapists' report of warm interpersonal style; Interaction with patients' pre-treatment interpersonal difficulties - association only found among patients with high levels of difficulties (Nissen-Lie et al., 2013)	No association (Nissen-Lie et al., 2013)	Negative association (Nissen-Lie et al., 2013)			
<u>4.2 Changes in patients' structural configurations</u>						
Overall personality configuration	Patients' negative life events – only patients with low improvement in overall personality configuration experienced deterioration depending on the amount of negative events in their lives (Huber et al., 2017)	Positive association (Huber et al., 2017)				Diathesis-stress model (Beck, 1967)
Anaclitic-introjective balance	Improved balance only associated with improved outcome in anaclitic and not introjective patients (Werbart & Forsström, 2014)	Negatively association (Werbart et al., 2017); Positive association only among anaclitic patients (Werbart & Forsström's, 2014)				Blatt's (2008) double helix model

Introject affiliation	No interaction with model of therapy (PD vs PA)	Positive association (Klug et al., 2017)		Not supported (Klug et al., 2017)	Self-representation theory (Jacobson, 1964) Psychoanalytic theory of defense mechanisms (Greenson, 1967) Psychoanalytic theory of patients' internalisation of analytic skills (Freud, 1937)
Defence mechanism		Positive association (Bond & Perry, 2004)		Positive association (Bond & Perry, 2004)	
Self-analytic skills	No interaction with model of therapy (PD vs PA)	Positive association (Falkenstrom, 2007)			
<u>4.3 The therapeutic relationship</u>					
Patients' experience of the therapeutic alliance		No association (Lilliengren et al., 2015; Lindgren et al., 2010; Solbakken et al., 2012)	No association (Lilliengren et al., 2015)	No support (Klug et al, 2012)	
Therapists' experience of the therapeutic alliance	Interaction with patients' baseline distress – negative association only found among patients with high level of distress	Negative association (Lindgren et al., 2010)		No support (Klug et al, 2012)	
Patient attachment to therapist		No association (Lilliengren's et al., 2015)	No association (Lilliengren's et al., 2015)		
<u>4.4 The therapeutic intervention</u>					
Dose		No association found (Huber et al., 2017; Lilliengreen et al., 2015; Lindgreen et al., 2010)	No association (Lilliengren's et al., 2015)	No support (supported only for the end treatment but not follow-up) (Huber et al., 2017)	
Model of therapy	Superior effectiveness mediated by more pronounced used of psychoanalytic technique (Zimmermann et al., 2015)	Superior effectiveness of psychoanalysis and psychoanalytic therapy (Huber et al., 2013; Sandell et al., 2000)	No association (Zimmermann et al., 2015)	Psychoanalytic technique identified as a differential mediator (Zimmermann et al., 2015)	
<u>4.5 Patients' pre-treatment characteristics</u>					
Affect integration difficulties		Positive association (Solbakken et al., 2017)	Positive association (Solbakken et al., 2017)		
Level of personality		No association (Knekt et al., 2017)			

## Appendix C: Ethical Approval



### National Research Ethics Service

#### West Midlands Research Ethics Committee

Osprey House  
Albert Street  
Redditch  
Worcestershire, B97 4DE  
nikki.murphy@westmidlands.nhs.uk  
Chairman: Mr Paul Hamilton

Tel: 01527 587581  
Fax: 01527 587503

02 February 2010

Professor Peter Fonagy  
Psychoanalysis Unit  
Research and Development of Clinical  
Education & Health Psychology  
10-19 Torrington Place  
London  
WC1E 7HJ

Dear Professor Fonagy

**Study title:** Randomised controlled trial comparing the effectiveness of usual GP care with once weekly psychoanalytic psychotherapy in cases of refractory depression  
**REC reference:** 02/7/035  
**Amendment number:** AM03  
**Amendment date:** 06 January 2010

The above amendment was reviewed at the meeting of the Sub-Committee held on 27 January 2010 by the Sub-Committee in correspondence.

#### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Private Theories Qualitative Interview Schedule	2	04 January 2010
Participant Consent Form: Treatment Group Patient Consent Form	2	
Participant Consent Form: TAU Group Patient Consent Form	1	04 January 2010
Participant Information Sheet: TAU Group Patient Information Sheet for Qualitative Interview	2	04 January 2010
Participant Information Sheet: Treatment Group Patient Information Sheet for Qualitative Interview	2	04 January 2010
Protocol	4	04 January 2010
Notice of Substantial Amendment (non-CTIMPs)		06 January 2010

### **Membership of the Committee**

The members of the Committee who took part in the review are listed on the attached sheet.

### **R&D approval**

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

### **Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

02/7/035:

Please quote this number on all correspondence

Yours sincerely

Miss Nikki Murphy  
Acting Committee Co-ordinator

E-mail:

Enclosures:

List of names and professions of members who took part in the review